#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** CAROL 2009 FLORA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ **x**F Months Days Director 382**-**36-2650 20, 1939 Michigan Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, I'm Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑No Maryland | Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 315 Tareyton Ct. 21014 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify **A** 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Public Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Forest LaVern Merrill Dorothy May Henderson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9614 Woodland Road, New Market, MD 21774

ce of Disposition (Name of Date 20c. Location - City or Town, State Michael S. Flora / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Servcie Corp. 7-10-09

22. Name and Address of Facility

McComas Funeral Home, P.A. Towson, Maryland The Fune of Service 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one can be carried to the complete shock of the carried shock of the carr ns bat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Encephalogathy disease or condition resulting in death) //Medical Examiner Astrocytomo Sequentially list conditions, Examine it any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): of Vital Records, P.O. Box 68760, attending physician Physician/Medical the ass IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Scieure disorder 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe Atrial Fibrillation 1 ☐ Yes 2 ☐ No 1 □Yes 2 **N**O Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🗷 No 2 this filled in by the funeral after death. 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending Injury 1 □Yes 2 □No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ٥ D0063498 Lives mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (akhr inder ladhwa 400 West Seventh St., Frederick, MD 21701 31. Date filed (Month, Day, Year) State JUL 1 0 2009 Registrar

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		•	for State Registrar		Olalo o	· maryian	C	ertificate	of Deat	th		Reg. No	).		
	Physici	an	1. Decedent's Name						1	2	Date of Dea	ath Da	y Year	3. Time of	Death
	/Medic	al	BERNARD] 4a. Facility Name (/	INE MARY		mher)		4h City Toy	wn, or Location	on of Death	ULY	4c.	. County of Deat	h Lid	8 H"
	Examin	er	1 11.0	en at	Riv 1	AIR		B	11 /	FIR	3		HAR	FURI	<b>)</b>
	Funeral		5. Social Security N	umber 6.5	Sex 1□M 2☑F	7. Age (In yrs.		Months D	Year If Und	rs Min.	Date of Birl (Month, Da	ıy, Year)	9. Birthplace (State or Foreign Country)		
	Director		218-07-75 Usual Residence of	561	200	9	O Yrs.				ct. 2	3, 1	L918 New	York	
	yland		10a. State	10b. County		10c. Cit	ty, Town or	Location			10d. Inside City Limits				•
S	e Mar 3a-fsh	ctor	Maryland	Harford		Bel	Air				1 □ Yes 2 ☑ N				2 <b>№</b> No
2	with the Maryland ia or 28a-f show	Funeral Director	10e. Street and Nur	mber				10f. Zip Co			10g. Citizen of What Country?				
2	death v	eral	302 Lee	Way		cedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spinores) 14. Was Decedent of Hispanic Origin? (Spinores) 15. Was Decedent of Hispanic Origin? (Spinores) 16. Was Decedent of Hispanic Origin? (Spinores) 16. Was Decedent of Hispanic Origin?					USA  Specify Yes or No- 14. Race - America				
215-0036	72 hours after death with the Marylar "natural", or items 23a or 28e-f show doel Evar	þ		ied 2 ☐ Married 4 ☐ Divorced	Armed Fo 1	es 2.1⊠No ,Give 1. □Yes 2.1‱INo <i>Specify:</i>				Puerto Rican, etc.) Black, V Specify:			e, etc. Thite		
5-0	72 hc "natur	letec	(Spec	15. Decedent's E cify only highest gr	ducation ade completed)		I (Gi	cedent's Usual C	done during n	nost of working		16b. K	(ind of Business	Industry	
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Sp	other other	BeC	17. Father's Name	(First, Middle, Lasi	")			HOKEL	18. Mc	other's Name (/	ner's Name (First, Middle, Maiden Surname)				
ylan	ould by Menta arked atic e	10		d John Ca			-			th Clev					
₩ r cyll	permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene Important: If item 27 is marked other than "nr any Injury or other traumatic event, the M all once.		19a. Informant's Na	ame/Relationship n Anne Ju				ailing Address (S )2 Lee W					or Town, State, . 21014	Zip Code)	
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Salti	epartr nporta ny Inju		21. Signature of Fu	ineral Selvi Lice	nsee	·		22 Name and A	Address of Fa	eral Hon	ne, P.	Α.			
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	Dharaisisa		23a. Part 1. Enter t shock, or hea Immediate Cause		one cause on e	each line.	1/-/	enter the mode t	i s d	i cardiac or	respiratory a	111631,		Approximat Interval Bet Onset and	tween Death
	Physician //Medical		disease or condition resulting in death)	on 🕜	a. Due to	(or as a conseq		eimer	3 U	136936					
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<b>.</b>	rtificate be executed ng physician and as the burial-transit	Examiner	that initiated events resulting in death)		c. Due to	(or as a consec	uence of):								
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ر. ح.	w requires that the de been signed by the should be detached	by Pr	Part II. Other signi	ficant conditions	contributing to d	eath but not res	sulting in the	e underlying cau	se given in Pa	art I.	23e. Did 1	tobacco	use contribute t	o the cause of	death?
ord	equire sen siç ould b	ted t									1 🗆	Yes 2	No 3□ F	Probably 4 🗌	Unknown
Division of Vital Records,	ding Physician: The law r h. After this certificate has be funeral director, page 2 sh	Completed		-							24a. Was auto perfo		_ death?	utopsy findings completion of o	available cause of
/ital	cian: ertifica ector, p	Be C	25. Was case refer examiner?	red to medical						Place of Death (					
of \	Attending Physician: r death. ector: After this certifics by the funeral director, p		1 ☐ Yes 2 27. Manner of Deat	•	Hospital: 1 28a. Date	·	ER/Outpa	tient 3 DOA	Other: 4	Nursing Home			6 ☐ Other (Spa	əcify)	
o u	ding th. : After funer	tion	Natural 2 Accident	5 Pending investigation	(Mor	oth, Day, Year)	Injur	M Zac	injury at Work? 1 □ Yes 2		u. Describe	now mje	ary occurred		
Divisi	I or Attendi after death. Director: A in by the fu	Certification: To	3 Suicide 4 Homicide	6 Could not I determined	1 28e. Place	e of Injury - At h ling, etc. (Speci	iome, farm,	street, factory, o	office	28	f. Location ( City or To		and Number or F te)	lural Route Nur	mber,
_	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one)	Certifying P	miner: On the b	basis of examin	ation and/o	r investigation, i	n my opinion,	, death occurred	d at the time	, date ar	nd place, and du	ie to the cause(	
	Fo the within Fo the	Med	and manner stated.  29b. Signature and title of certifer  29c. License number  D COG 398  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Benjamin Lee, MD 669 Revolution St. Havre de  31. Date filed (Month, Day, Year)  32. Registrar's Signature									29d. D	ate signed (Mon	ith, Day, Year)	
			•		2	~ M	D.		D 00	63981		Jul	148,2	1009	
	lov		30. Name and add		completed cau	se of death (Ite	m 23a) (Ty	pe, Print)	LL	de	C		100	21078	
	Sta	ite	31. Date filed (Mor	oth, Day, Year)	32. F	Registrar's Sign	ature	Wal.	1791	vre ae	Grac	21	WU '	21010	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend PI line a-d. 25 perME. 9893 7/10/09 TT
State of Maryland / Bepartment of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 9:10 James, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death City, Town, or Location of Death Examiner BALLIMORE MEDICALC SALtimoRe If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 Mary Land 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Nov 26, 1944 **Funeral** Hours Min. Days 218-42-4437 64 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Department of Health and Mental Hygiene. Important: I feen 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Exprision count by could be could as any Injury or other traumatic event, I'm Medical Exprision count by could be could be could be could be could be considered. Ceci1 1 TYes 2 No Director Maryland Perryville Center the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with USA 21903 152 Mill Creek Lane, Apt. 1203 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces:
1 Ayes 2 No
If Yes, Give
Year or Dates: Viet Nam 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) US Government Retired Army 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eleanor Baker Allen F. Gibbons, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2235 Cedley St., Baltimore, Maryland 21230 Henry W. Gibbons, Sr. (Brother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Bayview Crematory, Inc. 7/1/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furner Service Litternsee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Ave., Baltimore, Md. 21225-1856 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Acute lung injury** Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FIRS Physician Hodgkins Lymphoma

opic pregnanger (\*\* ^/Medical Due to (or a consequence of): Examiner Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): sician and burial-transit law requires that the death certificate be executed Sepsis Renal failure Due to (or as a consequence of): been signed by the attending physician should be detached for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown completely filled in by the funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 24a. Was an has Hospital or Attending Physician: The certificate 1 □Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes -EXN inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier rut Basi 18128 JUN 27, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PREET BA61 BALTIMORE, MD 21201 10 N. GREENE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 1 0 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** Ralph Irvin Glasgow, Jr. 03 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A eniversity If Under Year 8. Date of Birth (Month, Day, Year) July 9, 19 9. Birthplace (State or Foreign Country) istrict Of Columbia Social Security Number **Funeral** Days 1X M 2□ F 83 Yrs. 578-34-2374 1925 Director July Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the IM dio I Examiner must be notified at once. 1 ☐ Yes 🏋 ☐ No Director Maryland Severna Park Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 359 Prestonfield Lane 21146 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1944 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🕅 No 1945 þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electricial Engineer General Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ralph Irvin Glasgow, Sr. Mary Cacy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 359 Prestonfield Lane Severna Park, Maryland 21146 Stacey Tasker, Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory Inc. 07/08/09 Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor 22 Name and Address of Facility Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** day /Medical consequence of): **Examiner** Sequentially list conditions, if any teacing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) 9□Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 1 No 24a. Was an autopsy performed? Yes 2XINo ORONARY 25. Was case referre to medical examiner? 26. Place of Death [Check only one) in 24 hours after death.

the Funeral Director: After this ce examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 07-07-2009 61887 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 601 South Charles St. Baltimore ordelin 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JULY 3, 2009 4:06 P M JOHN ANTHONY GIBLIN 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) UPPER CHESAPEAKE MEDICAL CENTER HARFORD BEL AIR If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 X M 2 □ F July 14, 1933 132-24-1696 New York Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2€ No Maryland | Harford Bel Air 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 125 Briarcliff Lane USA 21014 12. Was Decedent Ever in U.S. Armed Forces? 1 ☆Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Insurance Company Manager 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William (nmn) Giblin Ellen (nmn) Flanagan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 125 Briarcliff Lane, Bel Air, Maryland 21014 Mary L. Giblin / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gdn: 7-8-09 Bel Air, Maryland 21. Signature of Juneral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 23a. Part1. Enter the disease, or complications hat odused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Julun Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 💆 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 2 X No 2 No 1 ☐ Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide † Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

law requires that the death certificate be executed 37354 ۵. Records. Vital Physician: of Attending Division 0 To the Hospital within 24 hours a To the Funeral E the Hospital

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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Director

Funeral

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Certification: To

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29b. Signature and title of certifier

is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene.
Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Modical Examples of the notiting at

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<u>≒</u> 5 Department of Important: If any Injury or once.

**Physician** /Medical

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After this certificate

death.

after death the

Maryland 21215-0036

Baltimore.

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State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

1171)

29c. License number

66641

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 9:00 AM 2009 ces Na 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) NIA 105 8. Date of Birth (Month, Day, Social Security Number Birthplace (State or Foreign Country) last birthday Year) Min 1 M 2 F Yrs ar Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1XYes 2 ☐ No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 300 21 WILKE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No Specify 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) omputer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) mull 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) aughle 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Surial 2 ☐ Cremation 4 ☐ Donation 与☐ Other (5 3 ☐ Removal from State த் □Other (Specify) 21. Signature of P neral Service License Jari Approximate Interval Between Onset and Death 23a. Part Lever he of ease, or complications that caused the death. Do not enter the mire of dying, such as cardiac or respiratory shoot or leart lailure. List only one cause on each line. Immediate Couse (Final disease or ondition resulting in death) or as a consequence of): Sequentially list conditions, drain, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: yes, outcome of pregnancy ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? ntributing to death but not resulting in the underlying cause given in Part I. 4 Unknown 2 No 3 Probably 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 211/10

**Physician** /Medical Examiner

Examiner

Physician/Medical

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Completed

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Medical Certification: To

the attending physician been signed by has After this certificate

23b. Was decedent pregnant	1 -
in the past 12 months?	
1 □Xes 2 □ No	
9 🗹 Unknown	
Part II. Other significant condition	ns con

	Thes 2 land 1 lates 2 land											
25. Was case referred to medical	26. Place of Death (Check only one)											
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)											
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)  28b. Time of Vork?  Injury  M  1   Yes   2   No											
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		r,										
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29a, Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

State

within 24 hours a To the Funeral C

person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Sign

/Medical Examiner **Funeral** 

Physician

Director

Funeral Director

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experiment to mailful at

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed Vital Records, P.O. Box 68760,

09-05324 Cedric Hart		Please Type or Print in Black Indelible Ink. Ensur State of Maryland / Department of Health an			le.	
odiio riait		1- For State Registrar Certificate of Death	id iviental Hygie	ene Reg. N	200	9 2200
Physici Medical Exami		Decedent's Name (First, Middle,Last)	М	ate of Death Ionth Da		3. Time of Death 1627 hrs
		CLDRIC HART	r Location of Death	ıly 6, 2009	4c. County of Death	
)		Johns Hopkins Bayview Baltimore				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Yea Months Day	vs Hours Min		M/DD/YYYY) 9. Birt Foreig	n
51100101		214-27-6328 1X M 2 F 19 Yrs. Months Day Usual Residence of Decedent		12/13/19	989 Co	untry) MD
any		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Aaryland <b>28a-f shuw</b> I at once.	or	MD BALTIMORE TURNER STATION				1 Yes 2 No
death with the Maryland or items 23a or 28a-f sho must be notified at once,	Director	10e. Street and Number 10f. Zip Code		10g. C	citizen of What Cour	ntry?
vith the s 23a r	alD	515 MAIN STREET 2122  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of His		Voc or No	USA 14. Race - Ameri	oon Indian Block
leath v	Funeral	I The Book and I The	n, Mexican, Puerto Ricar		White, etc.	can Indian, Black,
after or ral", n		3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No			Specify: BLAC	CK
136 thin 72 hours after te. than "natural", edical Examiner	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	ition (Give kind of work of DO NOT use retired)	done 16b	. Kind of Business/I	ndustry
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215-0036 be filed within 7 real Hygiene. rked other than ent, the Medica		THEVER WOR	t, Middle, Maide	. Maiden Surname)		
2121 2121 201d be fi Mental marked ic event,	Be	JAMES HOWARD, JR.  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street	KIMBERLEI			
MD 21215-0036 It should be filed within 72 hours after death with the Maryland th and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f shumatic event, the Medical Examiner, must he notified at once	٩	19a. Informant's Name/Relationship (Type, Print )  KIMBERLEIGH HART/MOTHER  515 MAIN ST				
무 등 등 등 등		20a Method of Disposition  20b. Place of Disposition (Name of cell crematory or other place)  20b. Place of Disposition (Name of cell crematory or other place)	emetery, Date		LAND 212 c. Location - City or	
Pages nent of		4 Donation 5 Other Specify: ST. STANISLAUS C	EM. 07/1	8/09	BALTIMORE	E, MARYLAND
Baltimore, permit. Pages I ar Department of Hee Important: If ite	-	Signature of Funeral Service Licensee 22. Name and Address	s of Facility JAMES	A. MOR	RTON & SON	IS F.H., INC.
Physician	-1	274 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying,	AURENS ST.	BALTIM	ORE. MD	21217 Approximate Interval
/Medical Examiner		failure. List only one cause on each fine.  Immediate Cause (Final disease a. <b>Drowning</b>		•		Between Onset and Death
Adminer		or condition resulting in death)  Due to (or as a consequence of):				
	ē	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last  Due to (or as a consequence of):				
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a a e	Physician/Medical	X UNPENDED AMENDED 23a,27,28a-f,perME, g	893 7/20/09	TT		
Box 68760, earth certificate be the attending physical of for use as the buri	M/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	Ectopic pregnancy	2	23d. Date of delivery	ay Year
ox 687 eath certific	sicia	past 12 months?  4 Pregnant at time of death 5 Other (Specify)			Wildright E	ay real
that the dened by the	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause of	oiven in Part I	23e Did tobaco	o use contribute to t	he cause of death?
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ivisi nr Att after de Direct	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office b		Location (Street	and Number or Rui	al Route Number, City
Divis  Hospital nr A 24 hours after  Funcral Directed filled in by	Se	4 Homicide determined (Specify) found in creek	Dur	idalk, l	MD	761
Division  To the Hospital In Atteowithin 24 hours after death To the Funeral Director:	Medical	Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, da one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion and manner stated.				
	ž	29b. Signature and title of certifier 29c. Licens		I .	Date signed (Mon	th, Day, Year)
bull		9M. H	м.Е.	_ Ju	ly 8, 2009	
1000		30. Name and address of person who completed cause of death (Item 23a)  Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Balt	timore, MD 21201			
St	ate	31. Date filed Wanth Day Y 2009 32. Registrar's Sanature			<u> </u>	
Regist	eΓ					

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 28b, e. &f per E g893 7/8/09 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20 Year 12:25 AM chae ar lo 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death of Mary las Bultimore Home Universita 76 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day) 1 2 M 2 □ F Months Days Hours Min 214-66-6348 Maryland 52 22 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d Inside City Limits MD Carroll 1 ☐ Yes 2X No Westminster 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 606 Old Bachmans Valley Rd. 21157 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Specify: white 1 ☐ Yes 2 🔼 No Specify. 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Business Owner Tree Removal 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Theodore Hart Jacqueline McClure 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21157 19a. Informant's Name/Relationship (Type, Print) Rebecca Hart-wife 606 Old Bachmans Valley Rd. Westminster, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 7-3-2009 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cem. 22. Name and Address of Facility Fletcher Funeral Home, P.A. 21. Signature of Funeral Service Licenses then homas 2 254 E. Main St., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Haro INJUR LINUS Due to (or as a consequence of): - navs MUCH NA ROVED BY MEDICAL EXAMIN Due to (or as a consequence of). Zhous BOLAN HauriASTON CERTIFICATION APP Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown

**Physician** /Medical **Examiner** 

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cate has been signed page 2 should be det

certificate

After this

within 24 hours after death To the Funeral Director:

funeral director.

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Completed

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Certification: To

Medical

the Hospital or Attending Physician: The law requires that the death certificate be exec

Division of Vital Records, P.O. Box 68760

**Physician** 

/Medical

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-1 show any linjury or other traumatic event, the Medical Event into Total be nothed once.

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examir burial-tran attending physician for use as the buria Physician/Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 1 □ Yes

23e. Did tobacco use contribute to the cause of death?

Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Date of Injury (Month, Day, Year)

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred 2 No

NES BRANCHITITHERD Location (Street and Number or Rural Route Number, City or Town, State) 4300 Green Glade

29/2059 9:05 am M 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Yard

Rd. Jacksonville, MD

29a. Certifier

25. Was case referred to medical

29b. Signature and title of certifier

1 Yes 2 No

27. Manner of Death

1 Natural

3 ☐ Suicide

4 Homicide

2 Accident

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Name and address of person who completed cause of death (Item 23a) (Type, Print)

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29d. Date signed (Month. Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

5 ☐ Pending investigation

6 ☐Could not be

determined

-2 32. Registrar's Signature

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** July 2, 2009 5:45 Helen May Herr /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Ridgeway Manor Nursing Home Baltimore Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace Country) (State or Foreign 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex **Funeral** Months Davs 1 □ M 2 □ F Yrs. 215-22-2058 81 Nov. 24. 1927 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Event in a fuer rullified at once. 1 ☐ Yes 2 📆 No Director MD Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 1131 Courtney Road 21227 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Howard Mercer Lottie May Sheppard ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ronald Herr - Son 1131 Courtney Rd., Baltimore, MD 21227

Page of Disposition (Name of Disposition (Name of Disposition) 20a. Method of Disposition Meadowridge Mellorial → Boxial 2 ☐ Cremation 3 ☐ Removal from State 7-9-2009 Elkridge, MD 4 □ Donation 5 □ Other (Specify)
Signature of tuneral Service Lineses Park 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final metas 11/247 **Physician** disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performer 1 ☐Yes 2 🕱 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To

P.O. Box 68760, Division of Vital Records.

/Medical

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

or 28a-f show

Baltimore, Maryland 21215-0036

examiner? 1 ☐ Yes 2 🌠 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	DOA Other: 4 Nursing H	ome 5 Residence 6 Other (Specify)					
27. Manner of Death 1 ⊠Natural 5 □ Pending 2 □ Accident investigation		28c. Injury at Work?  M 1 □ Yes 2 □ No						
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		28f. Location (Street and Number or Rural Route Numb City or Town, State)						
29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	hysician: To the best of my knowledge, death occuminer: On the basis of examination and/or investig and manner stated.	arred at the time, date and place ation, in my opinion, death occu	e, and due to the cause(s) and manner as stated.  urred at the time, date and place, and due to the cause(s)					
29b. Signature and title of certifier  Accepted Lay	or MD	29c. License number 29d. Date signed (Month, Day, Year)  July 2,2009						
30. Name and address of person who	completed cause of death (Item 23a) (Type, Print) MD 4367 Hollins form	, Ad , Baltin	reve, MD 21227					
31. Date filed (Month, Day, Year)	32. Registrar's Signature	,						
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Registrar DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 8<sup>Day</sup> **Physician** July 2009 2:30 P M Joyce Ε. **Holt** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Middle River 1309 Gunpowder Crossing Lane If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 225-32-9200 **78** July 26, 1930 Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Baltimore Middle River 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1309 Gunpowder Crossing Lane 21220 USA 23a death v Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? I and 2 should be filed within 72 hours after 1 Tes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 👿 Married altimore, Maryland 21215-0036 ō 1 ☐Yes 2 No Specify. Specify 2 3 Widowed 4 Divorced White natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. is marked other than Clerical Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Small Unk. ည Unk. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Item 27 i Robert G. Taylor husband 1309 Gunpowder Crossing Lane Middle River, MD 21220 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 o t Department of Important: If It any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 07/09/09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee George MacNabb 2. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road 21228 Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** MISDIONNORDEN disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner かんしょうしょうしん SCWOWN Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed NIMINI MINONIE BECARGIDODOD physician and s the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 menths? 1 □ Yes 2 ☑ No 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 4 Unknown 1 □ Yes 2 □ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No n 24 hours after death. e Funeral Director; A letely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and majner stated. 29a, Certifier Medical completely (Check only within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier HO057173 July 9, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 9110 Philadelphia RD, Suite 314 Baltimore, MD Huzefa Bahrain, D.O. 31. Date filed (Month, Day, Year) Registrar

8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min Months 220-74-7652 1X M 2□ F Yrs. **Director** May 6, 1958 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Example must be notified at Funeral Directo Maryland N/ABaltimore 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 3007 Mayfield Avenue 21213 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. à 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than College (1-4or 5+) Elementary/Secondary (0-12) 0th grade Youth Counselor 17. Father's Name (First, Middle, Last) Be William A. Hill 19a. Informant's Name/Relationship (Type. Print) of Health other t Department of Heal Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Memorial Park 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Theral Service Lice see shock, or heart fall Immediate Cause (Final disease or condition resulting in death) ure. List only one cause on each line ASCUD **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated event) Due to (or as a consequence of) Examiner physician and the burial-trans resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) I□Yes 2□No P.O. cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ Be Completed 1 ☐ Yes 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death After Injury 1 Natural 5 Pending 1 ☐Yes 2 ☐No investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide

10d. Inside City Limits 1 XYes 2 No 10g. Citizen of What Country? USA Race - American Indian, Black, White, etc. Specify: Black 16b. Kind of Business/Industry Woodbourne Day School 18. Mother's Name (First, Middle, Maiden Surname) Virginia Goodman 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 21213 Charissa Jocelyn Hill/ Wife 3007 Mayfield Avenue Baltimore, Maryland 20c. Location - City or Town, State Woodlawn, Maryland 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the Hospital or Attending Physician: The law requires that the death certificate be executed 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 410 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28d. Describe how injury occurred filled in by the fu 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Naremder Bharaj, MD 8813 Waltham Woods Rd Parkville, MD 21234 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 1 0 2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

#30 per DVR G893 7/10/09 TT
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Baltimore

7. Age (In yrs. last birthday)

Reg. No.

3

2009

4c. County of Death

N/A

Year

3. Time of Death

Birthplace (State or Foreign Country)

₽ M

2. Date of Death

Month

July

Registrar

1 - For State Registra

**Physician** 

/Medical

**Examiner** 

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

Ronald Kevin Hill, Sr.

Frankford Nursing and Rehab

4a. Facility Name (If not institution, give street and number)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

26 Per FH Phy G893 7/10/09 JH
State of Maryland / Department of Health and Mental Hygiene amend #26 Per 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 200 /Medical 4c. County of Death 4b. City, Town, or Location of Death tution, give street and number) 4a. Facility Name (If not inst **Examiner** N/ABo OUA If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex last birthday Date of Birth (Month, Day, Year) **Funeral** Months Hours Min. 1√ M 2 □ F S.Carolina 216-58-4862 68 7,1941 Director June Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiens. Interpretain it flems 71 an marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It a Pecalcul Examined that be profitted any Injury or other traumatic event, It allocates the second and the second that the second and 28a-f show 1 ☐ Yes 2 ☐ No Baltimore Director Maryland N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21216 2542 W. Lanvale Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Specify: Black within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No þ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Private Industry Landscaping <u>6th grade</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Virgin Shaw Richard Harrison, Sr. ပ 19b. Mailing Address (Street and Number or Ryral Route Number City of Town, State Zip (1992) 2542 W. Lanvale Street Baltimore, Maryland 19a. Informant's Name/Relationship (Type. Print) Annie Ruth Harrison/ Wife 21216 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Lansdowne,Maryland Zion Cemetery 7/7/09 Mt. 4 ☐ Donation )5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service 5240 Reisterstown Rd Baltimore, Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** /Medical resulting in death) Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consecutione of: Examiner burial-transit and Due to (or as a consequence of): To the Hospital or Attenuing ray control within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the aftending physician completely filled in by the funeral director, page 2 should be detached for use as the burian completely filled in by the funeral director, page 2. P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) 1 □Yes 2 □No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hiknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 2 No 2 No 1 □Yes 1 □Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 TNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OA Medical Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Aatural Division (Month, Day, Year) Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe

State Registrar

JUL 10

31. Date filed (Month, Day, Year)

32. Registrar's Signature

20006

Balten

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician Anna 2009 01 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Kandalls Tollal Huspital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🛛 F 79 Maryland 07/21/1929 220 22 1612 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2X No Director Anne Arundel Orchard Beach Maryland 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number ò U.S.A. 21226 7800 Waterview Drive or Items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 72 hours after 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Saltimore, Maryland 21215-0036 1 □Yes 2 No Specify Specify: White þ 3 Widowed 4 Divorced "natural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 72 th and Mental Hygiene. 7 Is marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) Westinghouse Electronics 7th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Max Schlichting, Sr. Alice Ann Cookson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is n any Injury or other traun Westminster, Maryland 21158 430 Uniontown Road Sharon Hall-Zeller / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Park 07/08/2009 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 Part 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Dentic disease or condition resulting in death) /Medical Due to (or a a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transi ryptoginic Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 D Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2121No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 patient 2 ER/Outpatient 3 DOA Certification: To this 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director: A letely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

Division of Vital Records, P.O. within 2 the

> State Registrar

5401 Court 31. Date filed (Month, Day, Year)

(Check only one)

29b. Signature and tile of certifier

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

40068505

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 11:05 AM RUBERT HICKMAN JULY 2009 03 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HUS PITAL BALTIMURE HARBOR BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1**x**□ M 2□ F 95 Maryland Director 213 05 6051 05/14/1914 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the findical Examination states in titled at Director 1 ☐ Yes 2X No Anne Arundel Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 312 W. Arundel Road 21225 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ▼Yes 2 No If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2x No Specify. Specify: 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Yard Clerk 12th Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur R. Hickman, Sr. Emma P. Powers ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health a
Important: If item 27 is
any Injury or other trau
once. Beverly Lewandowski / Daughter 722 Fairway Drive Annapolis, Maryland 21409 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, Crematory of Other (Specify) Entombment Loudon Park Cemetery 07/07/2009 Baltimore, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 ramerousky fions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Part 1. Enter the disease, or conven-shock, or heart failure. List only one Immediate Cause (Final VENTRICULAR ARRHYTHMIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine CORONARY ARTERY Physician: The law requires that the death certificete be executed burial-transt DISEASE and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) ☐Yes 2☐No the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ VASCULAR O IS EASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2☑No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 27. Man er of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after deatl Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records,

To the within 2

P.O. Box 68760

Baltimore, Maryland 21215-0036

State Registrar (Check only

29b. Signature and title of certifier

ANMOLDEEP BAJAJ, MD

BAJAT

5 HANGVER STREET 31. Date filed (Month, Day, Year) 32. Registrar's Signatur JUL 1 0 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

BALTIMURE,

000

MARYLAND

29d. Date signed (Month, Day, Year)

2009

JULY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#20b, perFH, G893, 7, 10, 709, WS
State of Maryland / Department of Health and Mental Hygiene 0 0

1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 06:20 FM HIRSCH 2009 6 **JOSEPH** Н /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE BALTIMORE COURTLAND GARDENS NURSING HOME | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 04/28/1914 Birthplace (State or Foreign Country)
 OH 6. Sex 14 M 2 F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Yrs. Director 218-14-5223 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County rel', or Items 23e or 28e-f show Examinating the natified at 1 Yes 2 No Completed by Funeral Director BALTIMORE BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21208 3703 TEAKWOOD DRIVE, APT. A-2 death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? permit. Pages 1 and 2 should be filed within 72 hours after 0 Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then "netural; or Iten eny injury or other treumetic event, the Neulical Exart 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) STATE OF MARYLAND 5+ ARCHIVIST 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be : HIRSCH **BECKY** VARANCHUK SAMUEL 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10 N. CALVERT ST., SUITE #300, BALTIMORE, MD 21202 ARDIE SHAW / GUARDIAN 20b. Place of Disposition (Name of cometery, crematory or other place)

ANSHE NIESEN 20c. Location - City or Town, State 20a. Method of Disposition 1) Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 07/09/2009 ROSEDALE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses Scott M 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Arten Pirearc Immediate Cause (Final Corenary 20 years **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examiner physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No jo 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 5 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 2 No Division of Vital Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27, Manner of Death Certification: After 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funerel D tixCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified DJ4053 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 14 25 mails St Keiltesting Rd 21136 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. lend 10e per FH 9893 7/10/09 TT State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month TONE **Physician** 200 JOHNSO /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner B4 LTIMORE CITY SANHPUTAN HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) ial Security Number 6 Sex **Funeral** 1□ M 2**X**F Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location artment of Health and Mental Hyglene. ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Every or other traumatic event, the Medical Every or other traumatic. 1 Yes 2 No Battimore Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number Kitmore Ad. 21239 Road Funeral . Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation December 5 usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Medica College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Informant's Name/Relation Department of Health an Important: If Item 27 Is any Injury or other trau once. 20a. Method of Disposition 7-2019 Raltimore, Maryland Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Greene FS. 14905 YOKKRS. Butto, My 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INTRACEPEBRAL HEMORPHAGE **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Properties the Euneral Director: After this certificate has been signed by the attending abused to the attending the state of burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death nse 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 3 ☐ Ectopic pregnancy for L Month Day Year 5 Other (specify) ned by the a 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No page 2 s 2 No 1 Tyes funeral director. 25. Was case referred to medical examiner?
1 Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Medical Certification: To 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 8b. Time of 28c. Injury at Work? Natural 5 Pending investigation 1 □Yes 2 □No Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completely fi (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number JUNE 30, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KER ITH JOSO BALTIMORE, MD 21238 5601 RAVEN 0 LOCH BUND 31. Date filed (Month Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July Day 2009<sup>ear</sup> 8, Jennifer Lorraine Johnson 8:35 P M 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Baltimore Gilchrist Hospice Center Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 7, Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Min. Hours Months Indiana 308-64-8261 55 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2X No MD Howard Eldridge 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 7990 Millstream Court 21075 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give <sup>A</sup> Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 □Yes 21√XNo Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Human Services Worker Howard County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Lee Jones, Sr. Geneva Vivian Harris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Fred Johnson (Husband 7990 Millstream Court Elkridge, MD 21075 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial Park 7/18/09 Elkridge, Maryland 22. Name and Address of Facility
Gary L. Kaufman Funeral Home at MMP, Inc.
7250 Washington Blvd. Elkridge, MD, 21075 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complicible in a that cause of shock, or heard failure. List only one cause on extraction in the cause of extractions of condition resulting in death) e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate
Interval Between
Onset and Death metrial CASCINOSACOMA Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a Was an autopsy performed?

1 Yes 2 No 26. Place of Death (Check only one) spice

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

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**Funeral** 

Director

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

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I Hygiene.

Department of Health and Mental Hygie Important: If Item 27 is marked other I any injury or other traumatic event, If

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requires that the death certificate be executed Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed certificate 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28b. Time of Injury Hospital or Attending Pl 24 hours after death. Funeral Director: After t 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check only one) To the I within 2 To the I 29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

N-Charles St. Balto Md

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

6701

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #5, perFh 8893 7/10/09 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Jenkins Samuel lune /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis Health Care Parkville Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 216 - 42 - 4574 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days 1**X**] M 2□ F Director 03 65 80 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 1 Yes 2 No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 23a 21239 U.S.A. 6936 Donachie Road Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. XNever Married 2☐ Married 1 Yes No If Yes, Give Year or Dates: 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black þ 3 Widowed 4 Divorced Specify: 'natural", Completed of Health and Mental Hygiene.
item 27 Is a rked other than "natu
other trau artc event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Univeristy Hospital 12th grade Laborer na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ Samuel Jenkins Edna Chavis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Roberts-Sister 1805 Sherwood Ave Apt B, Baltimore, Md 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Zion 4 Donation 5 Dother (Specify) 7-8-09 Landsdown, Md. 21. Signature of Funeral Service Licensee warch F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 10 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4□Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; / completely filled in by the fi 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) To the and manner stated. 29b. Signature and title of certifier 29c. License number 3642

JEY Y

DHMH 17 Rev 1/2001

State Registrar Rockville MP 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signa

31. Date filed (Month, Day, Year)

JUL 1 0 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 10:38AM 07 2009 Kandoll Leon /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Havre de Grace Harford Harford Memorial Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**⊠**M 2□ F 63 Yrs. May 29, 1946 Virginia 215-42-7654 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ir then "naturel", or itema 23a or 28a-f ehow the Medical Examinar must be notitled at 1X Yes 2 No Director Maryland Harford Aberdeen 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 464 Holly Drive 21001 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2X Married 1 ☐ Yes 2 ☑ No Specify: Specify: ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) e filed within all Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Heating & Cooling Co. 10 Repairman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Heelth and Mental is marked Jessie Frances Safewright Roy Leon Kitts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heelth a important: If item 27 is eny Injury or other tree 905. 464 Holly Drive, Aberdeen, Maryland 21001 Ruth M. Kitts / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 7-11-09 Aberdeen, Maryland Baker's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Amera Service Ligery McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one of that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, son each line. Approximate Interval Between Onset and Death cause Immediate Cause (Final **Physician** disease or condition resulting in death) angertile /Medical Due to (or as a consequence of) Examiner n dr Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit The law requires that the deeth certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice Be 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 Ho 1 Inpatient 2 2 P/Outpatient 3 DOA Division of 28a. Date of Injury (Month, Day Year) After th 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide pelli 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plane, and due to the dause(s) and manner is statled (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier D47804 30. Name and affire of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

A.MROWIEC

31. Date filed (Month, Day, Year)

Abendeen

32. Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#10e&19b, perFH, G893,7/10 09, WS

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** bara 12:07 A 80 2009 July /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner BALTIMORE TOWSON GREATER BALTIMORE MEDICAL CENTER If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Days Months 210-28-5140 Usual Residence of Decedent 1 □ M 2 🛛 F Director 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show be notified at Baltimore 1 XYes 2 ☐ No Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. 8tg-6 and Number ō th 21 211 S.H. 23a other traumatic event, the Medical Examiner : ust Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? or items 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Specify: White 人*は ナ/ く ひ*た) Maryland 21215-0036 1 ☐ Yes 2 No Specify: 9 72 hours Department of Health and Mental Hygiene
Important: If item 27 is marked other than "natural",
any injury or other traumatic event, the Medical Exp
once. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) Johns Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be pe P Pages 1 and 2 should 98 Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (Spuce Bal TIMOR 2121 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ★Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, 09 110 MO 21. Signature of Juneral Service Licenses neral chapel - monktor Rd. YOKK Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause and line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to or as a consequence of): POSTOSSADUTIVE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner be executed sician and burial-trans that initiated events resulting in death) Last to (or as a consequence of) physician at the burial Physician/Medical The law requires that the death certificate attending p for use as Box IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a Id be detached f P.0. 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 My Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy perform certificate of Vital 2 No 1 ☐ Yes 2 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death
1 X Natural
2 Accident Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie and address of person who completed cause of death (Item 23a) (Type, Print) W HARLON istrar's Signature 31. Date filed (Mo State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 06 Day July 200 gar **Physician** 6:25 P.M Carmela Frances Landry /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore County Baltimore 3104 North Wind Road If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Days Baltimore, MD. 1 □ M 2 🖺 F 67 Feb.07,1942 220-38-7134 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Maryland Baltimore Baltimore County Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21236 6 Joppa Wood Ct.Apt.A3 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after a Health and Mental Hygiene.
Im 27 is marked other than "natural", or itel ☐ Yes 22∑ No f Yes, Give 'ear or Dates: 1 ☐ Never Married 2 🖾 Married White 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **G&E** Contractors Book Keeper 12 N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carmela Ponticello Carmelo Mazzola 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2
Department of Health ar
Important: If Item 27 is n 21234 3104 North Wind Road Baltimore, Maryland Mr. Edward M. Landry (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date July 08, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Forest Hill, Maryland Evans Funeral Chapel 4 Donation 5 Dother (Specify) 2009 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.A
2325 York Road Timonium, Maryland 21093 21. Signature of Funeral Service Licensee c, Complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, but hely one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter de di ease shoot o he il fai re. Immediate Cause (Final) disease or condition resulting in death) cancer ancreatic **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-tran Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 HOther (Specify) Sisters 2No 1 Tyes 1 Inpatient 2 ER/Outpatient 3 □ DOA ၉ 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical end manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

attending pl for use as t this 24 hours after death.

Funeral Director: A etely filled in by the fu 24 hours within 24 hor To the Fune completely fi

death with the Maryland

Lanary

Frances

3altimore, Maryland 21215-0036

5 State Registrar

DHMH 17 Rev 1/2001

NISHI 32. Registrar's Signature 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

M.

4920 Campbell Blud, Baltemere, MD 21236

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year Physician /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and nur 4b. City, Town, or Location of Death **Examiner** mare 8. Date of Birth Month, Day, 6. Sex yrs. last birthday) **Funeral** Months Days 1 M 2 □ F Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hjury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13. Was Decedent of Hist If Yes, specify Cuban, Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 19a, Informant's Name/Relationship (Type) MU 21050 20a. Method of Disposition 20c. Location 1 Burial 2 □ Cremation 3 □ Removal from State 3a/timore, mo 4 □Donation 5 □ Other (Specify) I Service Licen / e 21. Signature of Funer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) SMOCK **Physician** SEPTIL /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? RENA DUFYBUE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perforn To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 npatient 2 ER/Outpatient 3 DOA s after death.

I Director: After this of in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 Tyes 3 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours and
To the Funeral Dir 29a. Certifier CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) K, SARWARE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4016/10 SPUAMZE 1SAR MORRE 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 062 /Medical 4c. County of Death or Location of Death 4a. Facility Name (If not institution give street and number) **Examiner** timore Union Memona If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months 1 M 2 F 217-84-7668 Usual Residence of Decedent Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evarians must be notified at by Funeral Director Maryland 10g. Citizen of What Gountry? 10f. Zip Code 10e. Street and Number 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. ☐Yes 2MNo Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Şegondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) oulse 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Marylar Thomas Lewis-Mother Lowise 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition permit. Pages Department of Important: If It any injury or o 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician seizure /Medical Due to (or as a consequence of): Examiner Brain metastasis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of Nonsmall cell lung cancer attending physician and for use as the burial-transit P.O. Box 68760, Neutropenia IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month 1 ☐ Yes 2 ☐ No Par

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

To the Hospital or Attending Physician: The law requires that the death certificate be executed s been signed the should be detailed Division of Vital Records, within 24 hours after death.

To the Funeral Director: After this

þ Completed Certification: To

25

27

Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

9 Unknown												
t II. Other signific	ant conditions o	ontributing	g to death but not res	ulting in the unde	erlying	cause given ir	Part I.			use contribute to the cause of death?		
				pe pe	as an atopsy erformed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No						
Was case referre	d to medical					26	. Place of Dea	th (Check on	ly one)			
examiner? 1 ☐ Yes 2 ☑ N	•	Hospital	0.11						me 5 Residence 6 Other (Specify)			
Manner of Death 1 ☑ Natural 2 ☐ Accident	5 Pending investigation		(Month, Day, Year) Injury Wo			28c. Injury at Work? 1 ☐ Yes	3 2 □ No	28d. Descri	28d. Describe how injury occurred			
3 Suicide 6 Could r 4 Homicide determ			e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)			

and manner stated

, MD

QUIANZON

State Registrar AT2438946

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

3. Time of Death

02:20 A M

9. Birthplace (State or Foreign Country)

ylar

Inside City Limits

1 Yes 2 No

Approximate Interval Between ~ month

U month

2 3 years

1 month

Day

Year

July, 06, 2009

person who completed cause of death (Item 23a) (Type, Print)

MD, Union Memorial Hospital, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician REGINALD 5:30 PM 2009 6 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore Future-Care Sandtown Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 <del>Q</del> M 2 □ F Yrs 218-62-9330 Director 1955 Maryland March 1, 54 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show r than "natural", or items 23a or 28a-f shout the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Maryland N/A Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1702 N. Smallwood Street 21216 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☆Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 marked other than "natural", or 1 ☐ Yes 21 No Specify Black ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed 12th grade Construction Worker injury or other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othany injury or other traumatic Avent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alphonza Lee Hattie Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21 2 3 9 19a. Informant's Name/Relationship (Type. Print) Nichelle Gray/ Niece 1323 Silverthorne Road Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 7/14/09 Woodlawn, Maryland 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licenses 5240 Reisterstown Rd Baltimore, Md 21215 ares 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** MYPERTENSIVE CARDIOVASCULAR DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and Due to (or as a consequence of) physician a the burial-t Box 68760. Physician/Medical attending p for use as t IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year P.0. s been signed by the s 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown DIABETES MELLITUS Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy page performed certificate 1 XYes 2 □ No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural within 24 hours after community the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number DU05910 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 2/136 210 BUSINESS CENTER DRIVE REISTERSTOWN

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

09-05291 Willie Henry Livingston

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 22025

		- For State Registrar	Č	ertificate o	f Death			Re	eg. No.				
Physicia	ın/	Decedent's Name (First, Middle,Last	t)					Date of Deat Month	h Day Yea		Time of Death		
ledical Exami	-	Willie Her		ingsto			J	uly 5, 200	09		1736 hrs		
		4a. Facility Name (if not institution, give	re street and number)			n, or Location o	of Death		4c. County	of Death			
		Bon Secours Hospital			Baltimor		- 0411 10	Date of Dia	th(MM/DD/YYYY	O Diethol	ann (State or		
Funeral	ı	5. Social Security Number 6. S $217-66-4275$		rs. last birthday)	If Under 1 Months	Days Hours	1.00		•	Foreign			
Director		217-00-4273	M 2 F	51 Y		,		08/17	7/1957	Country	y) MD		
>	ļ	Usual Residence of Decedent	40.	City, Town or Loca	ation.					10.	d. Inside City Limits		
* an		10a. State 10b. County BALTIN		BALTIMO							Yes 2 X No		
Maryland 28a-f show any d at once.	ġ.		IONE	DAULTIN					0g. Citizen of WI				
Mary 28a-	Director	10e. Street and Number			10f. Zip Co				3		ſ		
h the ! 3a or		4710 Amberley			212				US.				
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sho natic event, the Medical Ex minier must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Married	12. Was Decedent Ever in Armed Forces?			of Hispanic Drig uban, Mexican,				e - American e, etc.	Indian, Black,		
	Fu		1 Yes 2 X N	lo	V 0 V	No openful			Specify:	Bla	als		
rs afte ural" mine	۵	Widowed 4 Divorce      Decedent's Education (Specify of the content of the c	ed if Yes, Give Year 1 Yes 2 X No specify: or Dates:  only highest grade completed)   16a. Decedent's Usual Decupation (Give kind of work						16b. Kind of Bu				
hou "nate	ĘĘ.	Elementary/Secondary (0-12)	College (1-4 or 5+)		during most of working life. DO NDT use retire						,		
21215-0036 oold be filed within 72 if Mental Hygiene. s marked other than "it event, the Medical.	Completed	11th	NA	Move	er				Cadil.	lac M	lovers		
d wit	팃	17. Father's Name (First, Middle, Las	)			18.Mother	's Name (Fi	irst, Middle,	Maiden Surname	∍)			
21215-0036 Auld be filed within 7 Mental Hygiene. marked other than	Be (	Robert Linings	ton Livings	ton		Virt	tlee	Hort	on				
213 ould b		19a. Informant's Name/Relationship (	Type, Print )	19b. Maili	ng Address (	Street and Num	nber or Rura	al Route Nur	nber, City or Tov	vn, State, Zir	p Code)		
MD d 2 sho Ith and n 27 is aumati		Rose Livingsto	n - Sister	4710	) Ambe	rley A	Ave.	Balt	o., MD				
		20a. Method of Disposition	□ a l	0b. Place of Disponental Observatory or of the Company of the Comp	other place)			ate	20c. Location	- City or Tov	wn, State		
Baltimore, permit. Pages I ar Department of Hee Important: If ite njury or other tr		1 X Burial 2 Cremation 3 4 Qonation 5 Other Specify	ı r	King Me	moria:	l Park	7/1	4/09	Randa.	llstc	own, MD		
Baltimo permit. Page Department Important; injury or otl	İ	21. Signature of Funeral Service Lice	nsee	22.	Name and Ad	dress of Facility	Y		st, In				
in in per m		Mumi	D.K.o.k.	Ma 14.3	arch F 300 Wa	unera. bash A	L HON	ne we	st, In	C. D. 21	215		
Physician		23a. Part I. Enter the disease, or com	Sa. Fart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart										
/Medical		failure. List on one cause on each line.  Immediate Cause (Final disease a, Atherpsclerotic Cardiovascular Disease between the cause (Final disease and the cause (Final disease (Final disease (Final disease (Final disease (Final disease (Final dis											
xaminer		or condition resulting in death)	Due to (or as a consequen-										
	L	Sequentially list conditions,								-			
	<u>.</u>	if any, leading to immediate couse. Enter Underlying Cause	Due to (or as a consequen-	ce ot):									
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760, cate be execut physician and he burial - tran	/Medical	UNPENDED	AMENDED #17 P	er rn Go	171	3/09 11				-			
76 cat	1	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of	pregnancy					23d. Date of	-	Voor		
ox 68' eath certiff attending for use as	jan	past 12 months?	1 Live birth Pregnant at time of	of death		3 Ectopi	c pregnanc	У	Month	Day	Year		
Box 68 death certif the attending	Physician	1 Yes 2 No 9 Unknow		5	Other (Specify								
P.O. B. that the de		Part II. Other significant conditions	contributing to death but r	not resulting in the	e underlying ca	use given in Pa	art I.	23e. Did	tobacco use cont	tribute to the	cause of death?		
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tal certi	Be	25. Was case referred to medical examiner?	Hospital:	4 550		Place of Death Other			Desidence C	Othory			
F Vi Physical dir	ို	1 ✓ Yes 2 No 27. Manner of Death	I Inpatient 2	28b. Time of		. Injury at Worl		Home 5	Residence 6	Other:			
n of \ding Phy.  After tl  funeral	Ë	1 V Natural	28a. Date of Injury (Month, Day,Year)	Zob. Time C		Yes 2	_	ou. Describe	TIOW HIJOTY GOOD	1100			
SiO Vitten death death	cati	2 Accident Pending Investiga		At home form of			-	Of Looption	(Street and Num	hor or Pural	Route Number, City		
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been s led in by the funeral director, page 2 should I	Certification:	3 Suicide 6 Could no determin		At nome, rarm, st	reet, ractory, o	ince building, e	FIC.   20	or Town,		Del Of Rural	Note Namber, Only		
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier	cian: To the best of my know	wlodge docth co	nurrod at the 4	ne data and -1	laco and d	in to the ser	ise/s) and mars	er as stated			
the H tin 24 the F	ica	(Check only   Gentilying Filys)	er:On the basis of examinati	ion and/or investi	gation, in my o	oinion, death o	ccurred at t	he time, date	e and place, and	due to the c	cause(s)		
To To com	Medical	29b. Signature and title of certifier	and manner stated.			icense number			29d. Date sig				
		/ / / Pa.				D.C.M.E.			July 6, 20	109			
		30. Name and address of person who	completed cause of death	(Item 23a)									
			stant Medical Examin		nn Street, E	Baltimore, N	/ID 2120	1					
S	tate	31. Date filed (MOT), Day, Oar)			Kel				<del></del>				
Regis		JUL 1 0 700	M Renewa	H. KATUM	-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death  $A^{M}$ **Physician** 2009 1:35 Matuszak July 5, Judith L. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Fort Washington Hospital Fort Washington | Trunder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 20, 1 9. Birthplace (State or Foreign Country) New York 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1 □ M 2 🛛 F 1942 67 Director 081-36-8889 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland nd Mental Hygjene. marked other than "natural", or items 23a or 28a.4 show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modeal Examinar mast be malified at 1 ☐ Yes 2 🔯 No Director Orchard Park New York Erie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 14127 U.S.A. 65 Minden Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dance Academy Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be f Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve Priscilla Henning Elmer Pickhardt ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) NY 14224 West Seneca, Michael Grob (Son) 102 Hemlock 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 07-10-2009 Hamburg, NY Hillcrest Cemetery 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Liousee 22. Name and Address of Facility Lombardo Funeral Home 3060 Abbott Rd., Orchard Park, NY 14127 un lluna 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Atheroscieratic Coronar **Physician** /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month Dav 5 ☐ Other (specify) signed by the a d be detached fo 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 Hypertension 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen Mellitus 24b. Were autopsy findings available prior to completion of cause of death? Diabetes 24a. Was an autopsy has 2 No 2 No certificate 1 ☐ Yes 1 ☐Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ this 28a. Date of Injury (Month, Day, Year) completely filled in by the funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t 27. Manner of Death After Certification: 1 WNatural 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier MP

10 V

State Registrar Deepak Dachdeva, M.D.

31. Date filed (Month, Day, Year)

JUL 10 2009

32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11711 Livingston Rd., Fort Washington, MD 20744

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM/196, perff, G894, 8/3/09, WS

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No./ 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death JULY **Physician** 2009 **JEANNETTE** MARCOPOULOS 14:28 J. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner UPPER CHESAPEAKE BEL AIR BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/07/1936 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Months Hours NEW YORK 73 Director 043289766 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Incideal Examiner must be notified at 1 ☐ Yes 2X No Director MD HARFORD BEL AIR 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 555 ATWOOD ROAD APT. 102 21014 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify Specify: WHITE <u>≥</u> 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Health and Mental Hygiene. tem 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 0 CLERK ABANDON VEHICLES BALTO, CITY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOHN **HEGYI** ROSE KELEMEN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1400 WOODEN BRANCH CT BAL AIR, MD 21014 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 is any injury or other tra DONNA BARTYNSKI/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 7/11/09 4 Donation 5 DOther (Specify) GARDENS OF FAITH BALTIMORE, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Se BALTIMORE, MD 21237 1211 CHESACO AVE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 48 HOURS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** LUSTRIDIVM Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: Box 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) signed by the ad be detached to o 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed this certificate 1 □Yes 2 ■No 1 Yes Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To ō 28b. Time of Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred ne Hospital or Attending P n 24 hours after death. he Funeral Director; After After Division 1 Alatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specity) 4 Homicide 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ical 29a. Certifier (Check only one) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature ar ess of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add Jason Birnbaum m. O. 500 Upper Chesapeake 31. Date filed (Month, Day, State 1 0 2009

Registrar

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Jeanette

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			For State Registrar			Ce	rtificate of	Death		Reg. No	09	22028	
	Physici /Medi		Decedent's Name (First, Middle, IMARION	Last)		MA	RCUS		Jule 18 2009			3. Time of Death  5 10 9 A M	
	Examir	er	4a. Facility Name (If not institution, g KESWICK MULTICA)  5. Social Security Number 6	RE		last birthday)	4b. City, Town, BALTI If Under 1 Yea			4c. County	N	I/A e (State or Foreign	
L	Funeral Director		215-22-3149 Usual Residence of Decedent	1□M 2X F		36 Yrs.	Months Day			1922	Country)	OH	
	arylan show	_	10a. State 10b. County	ty, Town or Le					10d.	Inside City Limits			
	the Ma 28a-f	Director	MD N	/A	BALTIMORE 10f. Zip Code						What Country?	1 X Yes 2 No	
	3a or	Ö	6105 WESTCLIFF	DRIVE			Toi. Zip Code	21209		rog. Onizen or		USA	
036	be filed within 72 hours after death with the Maryland that Hygiene.  4d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Xidowed 4 Divorced	12. Was Decede Armed Force	es? XNo	J.S. 13.	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☒ N	Hispanic Origin? (Siban, Mexican, Puer	Specify Yes or No to Rican, etc.)	ecify Yes or No- Rican, etc.)  14. Race - A Black, W Specify: W			
5-0	72 ho	eted	15. Decedent's (Specify only highest)			16a. Dece	dent's Usual Occ	upation e during most of wo	rking	16b. Kind of B	usiness/Indust	try	
121215-0036	filed within Hygiene. other than '	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	1	(Give kind of work done during most of life. DO NOT use retired)  LAB TECHNICIAN			HEALT	HEALTHCARE		
and	eve eve	o Be	17. Father's Name (First, Middle, La LOUIS	SI)		TUNICK		BERTH/	, .	e, Maiden Surnar	EDLIN	FDI TN	
Maryland	S D E E	오	19a. Informant's Name/Relationship	(Type. Print)			•	et and Number or R		per, City or Town,			
	5 = N L		WARREN MARCUS / SON 12817 GLEN MILL ROAD, POTOMAC, MI							, MD 208			
Baltimore,	of of the second		20a. Method of Disposition  1   Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spe		ate OH	ſĔB <sup>ŧe</sup> ŠĤĀ MORIAL	osition (Name of matory or other p PARK	lace) 06/1	Date 19/2009	20c. Location	ERSTOWN	N, MD	
Ball	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Lic	ROS., I	21208								
>	Physician /Medical Examiner		23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a. Rava	h line.	th. Do not en	ter the mode of d		c or respiratory	arrest,	Ar Int	pproximate Iterval Between Inset and Death	
	ed isit	niner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):						TVAMINER			
68760,	ficate be executed g physician and as the burial-transit	dical Examiner	that initiated events resulting in death) Last	cDue to (or	as a consec	CERTIFICATION APP	CERTIFICATION APPROVED BY MEDICAL EXAMINER						
P.O. Box 6	the death certi by the attending ached for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 □ Yes 2 ☑No 9 □ Unknown  23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)									ay Year	
	es that igned to be deta		Part II. Other significant conditions	s contributing to deat	h but not res	sulting in the u	inderlying cause	given in Part I.	23e. Did	tobacco use con	tribute to the o	cause of death?	
ord	w require been si should b	ted	ving disease	secondo	vey 1	wien	e chape	nous	10	Yes 2 No	3 ☐ Probabl	ly 4 Unknown	
al Rec		Completed by	Left hip and ri	,		ancio	daron	2 texicit	24a. Was auto perf 1 Yes	opsy formed?	prior to compl death?	y findings available letion of cause of	
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1 0	g Physer this seral di		27. Manner of Death	28a. Date of I	njury	28b. Time of Injury	III JUDON	4 Menursing i	28d. Describe	idence 6 □Otl how injury occur	red		
Division or Vital Records,	al or Attending F after death. I Director: After d in by the funer.	Certification:	1 ☐ flattural 2 ☐ Recident 3 ☐ Suicide 4 ☐ Homicide  5 ☐ Pending investigat 6 ☐ Could not determine	May 8,			□Yes 2 <b>X</b> No	ber or Rural R	of a chair Route Number, tcliff Dr				
	To the Hospital or Atte within 24 hours after dea To the Funeral Directo completely filled in by th	Medical C	29a. Certifier (Check only one)	Physician: To the be aminer: On the basi and manner	s of examina	owledge, dea ation and/or in	th occurred at the	time, date and place y opinion, death occ	e, and due to the	ore, MD e cause(s) and m e, date and place,	anner as state and due to th	ed. ne cause(s)	
	To the within To the comple	Me	29b. Signature and title of certifier	and mainter	Stateu.		29c. Lice	nse number		29d. Date signe	ed (Month, Day	y, Year)	
			Dr Badelle Vo	ie Gregor	C112		D	13657		Ture 18, 2009			
0			30. Name and address of person who TRIBBELLE TV	Le Co Fiel	of death (Iter	m 23a) (Type,	Print)	E7,BALI	IDORE				
X	Sta Registi	ite 'ar	31. Date filed (Month, Day, Year)	9 Arrange	istrar's Son	atur (1)							

09-0528	35		
Donald	N	Miller	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		I- For State Registrar	Cert	ificate o				g. No. 2.0	09 2202	
Physicia	an/	Decedent's Name (First, Middle,Last)					Date of Death     Month		3. Time of Death	
Medical Exami		Donald Norman Mil					Month July 5, 200		1130 hrs	
		4a. Facility Name (if not institution, give stree 9800 Cherry Hill Road #41	et and number)		4b. City, Town, or Beltsville	Location o	of Death	4c. County of De Prince Geor		
E		5. Social Security Number 6. Sex	7. Age (In yrs. la:	et hirthday)	If Under 1 Yea	r I if I inde	r 24Hrs. 8. Date of Birt	th (MM/DD/YYYY) 9. Birthplace (State or Foreign		
Funeral Director					Months Day		Min.	Country)		
	-	168-48-5411 1X M  Usual Residence of Decedent	2 F 54	Yrs	i.		July 6	, 1955 E	ennsylvania	
any	-	10a. State 10b. County	10c. City,	Town or Locat	tion				10d. Inside City Limits	
<b>*</b> .		Maryland Prince Geo	rge's Re	ltsvíl	م1				1 Yes 2 X No	
vlaryland 28a-f show 1 at once.	~ L	10e. Street and Number	orge 5 De	TEDVII	10f. Zip Code	-	10	g. Citizen of What C	ountry?	
he Ma or 2	Ei.	9800 Cherry Hill Ros	ad #41		20740			U.S.A.		
ath with the Maryland Hems 23a or 28a-f sho ist be notified at once		11. Marital Status 12.	Was Decedent Ever in U.S				nin? ( Specify Yes or No-		nerican Indian, Black,	
leath	Funeral	1 Never Married 2 Married	Armed Forces? Yes 2 X No	lf Y	es, specify Cubar	, Mexican,	, Puerto Rican, etc.)	White, etc		
after o	by F	3 XWidowed 4 Divorced If Yes		1	Yes 2 X No	specify:		Specify: Wh	ite	
ours atur		15. Decedent's Education (Specify only high	hest grade completed)		nt's Usual Occupations of working life			16b. Kind of Busines	ss/Industry	
6 n 72 h	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)				,	0 1		
withi giene.	Ē	17. Father's Name (First, Middle, Last)	5+	Compu	ter Engi		's Name (First, Middle, N	Geologie	es	
15-	Be C	Donald Norman Mille:	r				othy Janice			
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 'is marked other than "natural", or Hems 23a or 28a-f she natic event, the Medical Examiner must be notified at once		19a. Informant's Name/Relationship (Type, F	ber, City or Town, St	ate, Zip Code)						
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examines		Justin Eric Miller	(Son)	2816	A. Saum	svill	e Rd., Mau	rertown. V	A 22644	
e, e, l and l and Healt litem	- 1	20a. Method of Disposition			sition (Name of ce		Date	20c. Location - City	or Town, State	
Baltimore, permit. Pages I an Department of He Important: If ite		1 Burial 2 X Cremation 3 R 4 Donation 5 Other Specify:	emoval from State Omp	s Crem			7/9/09	Winchest	Winchester, VA	
altir mit. P porta ury o	1	21. I gnature of Funeral Service Licensee	/	22.	Name and Address	of Facility	7 77			
E E G E		Leung Ist	un	15 15	7 N. Mai	n St.	al Home , Woodstoc	k, VA 2266	54	
Physician		23a. Part I. Enter the disease, or complication failure. List only one cause on each lin		Do not enter	the mode of dying,	such as c	ardiac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and	
/Medical xaminer	1		Diabetic ket		sis				Death	
1		or condition resulting in death)  Due to	o (or as a consequence of	):						
	<u>ا</u>	Sequentially list conditions, if any, leading to immediate Due to	o (or as a consequence of	):					-	
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'60, rate be ohysicia ne buria	Medical	IF FEMALE: 23	ENDED 23a, pt per me g893 c. If yes, outcome of pregr	7-30-	09 vt	8070		23d. Date of deli	verv	
587 rtifica ling pl		23b. Was decedent pregnant in the past 12 months?	Live birth		etal death 3	Ectopi	c pregnancy	Month	Day Year	
Box 687 he death certific the attending p	sici	1 Yes 3 No 9 Heknown	Pregnant at time of dea	ath 5 O	ther (Specify)			1813		
the de ched f	Physician	Part II. Other significant conditions cont	Unknown	sulting in the	underlying cause	given in Pa	art I. 23e. Did to	obacco use contribute	e to the cause of death?	
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ds, equire	Completed by						24a. Was		e autopsy findings available	
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Division of Vital Records, ital or Attending Physician: The law requir rs after death.  al Director: After this certificate has been sed in by the funeral director, page 2 should the funeral director, page 2 should the funeral director.	Be	25. Was case referred to medical examiner?	al: 1 Inpatient 2	ER/Outpatien		Other	(Check only one)  Nursing Home 5	Residence 6 🗸 C	ther: Scene	
n of V ling Phy After thi funeral d	٠ <u>.</u>	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time of		ry at Work		how injury occurred		
on ( arh. r: Af	tion	1 X Natural 5 Pending	(Month, Day,Year)		1	Yes 2	No			
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Division of Vital Records, P.O. Box 681 To the Hospital or Attending Physician: The law requires that the death certiff within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certification:	Suicide 6 Could not be determined	(Specify)				or Town, S	state)		
Hosp 24 ho Fune			o the best of my knowledg							
To the Hos within 24 h To the Fun completely	Medical		he basis of examination ar manner stated.	nd/or investiga			ccurred at the time, date			
->F0	ž	29b. Signature and title of certifier	, , , , ,	/	29c. Licen:			29d. Date signed	(Month, Day, Year)	
		9,	M. K		O.C.	M.E.		July 6, 2009		
MI		30, Name and address of person who comp			04 5		ND 04004	_		
OV			of Medical Examiner		nn Street, Ba	ıtımore,	IVID 21201			
St Regis	tate trar	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	4 1	a. el 1					
DHMH 17 Rev 1/2			1	ORIGINA	N.				Colvic	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last, 1639 M Month Day **Physician** George Myett /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** University of Maryland Medical Center Baltimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1**∑** M 2□ F 01/17/1957 New Jersey Director 139-56-9619 Usual Residence of Decedent 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other than "natural" or items 23a or 28a-f show other traumatic event, the Medical Experience, ust be netfled at 1√2 Yes 2 □ No Lanham Prince Georges Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20706 9109 8th Street 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2√☐No Specify: Specify: White ₫ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) unk Pages 1 and 2 should be filed within of Health and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Charlotte Hamsworth George J. Myett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20706 Jessie Peris/Girlfriend 9109 8th Street, Lanham, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of I Important: If ite any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Cremation Services 07/10/2009 Hanover, Maryland 22. Name and Address of Facility Ardent Cremation Services 21. Signature of Funeral Service Licenses Laura C. Hardesty M01197 7522 Connelley Drive, Ste.N, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Multi Organ **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sepsis Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Liver Disease Physician: The law requires that the death certificate be executed and burial-trar Box 68760 attending physician Physician/Medical the as IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Year Month 0 Day 5 Other (specify) 1 □Yes 2 □No P.O. ed by the 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 s has 1 ☐Yes 2 ☐No certificate 1 ☐ Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t Certification: Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated To the I within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier NPI 1104051945 Medical Doctor 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 21201, Elizabeth K. Smetter Greene 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

09-05113 Richard Myers

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		For State										No. ZU	09 220	J
Physician/		. Decedent's Name (Fire	st, Middle,Last	)			Date of Death     Month					ay Year	3. Time of Death 2013 hrs	
ledical Examine		Rick	nard		My	ers				JL	ine 28, 200	4c. County of De		
	4	a. Facility Name (if not Frederick Memo			umber)/			. City, Town, or Li Frederick	ocation of	Death		Frederick	5401	
	<b>.</b>				7 Ago (In	yrs. last birth		If Under 1 Year	If Under	24Hrs. 8.	Date of Birth(	MM/DD/YYYY) 9	. Birthplace (State or Fore	eign
Funeral Director	5	Social Security Number		_	7. Age (in			Months Days	Hours	Min			Country)	
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<u> </u>	_	Jsual Residence of Dec 0a. State 10b.	County		10c	City, Town	or Location	1					10d. Inside City Limi	its
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i, or		3 Widowed 4	Divorced	1 Yes If Yes, Give Ye	2 L	No	1 \	res 2 No	specify:			Specify:	white	
72 hours after death with the Maryland n "matural", or items 23a or 28a-f she al Examiner must be notified at once	દ⊩	15. Decedent's Educat		or Dates:		ed) 16a.	Decedent's	Usual Occupation	on (Give ki	ind of work	done 1	6b. Kind of Busin	ess/Industry	
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036 ithin ne.	릴	12				E	arm	1 labor	rer			Agricu	lture	_
215-0036 be filed within nital Hygiene. rked other that ent, the Medit		17. Father's Name (First	t, Middle, Last)				•	1	8.Mother's	s Name (Fir	st, Middle, Ma	iden Surname)	1	
1 21215-0036 hould be filed within 72 hours after de defined byggiene, is marked other than "matural", or ritic event, the Medical Examiner mu	200	Alvin L	-ee	W.	1845				01/	ve	1Vlin	er, City or Town,	State Zin Cada)	-
D 2121 should be f and Mental 7 is marked natic event,	2	19a. Informant's Name/	Relationship (T	ype, Print		- 1		Address (Street	and Numi	ber or Rura	Route Numb	er, City or Town,	State, Zip Code)	,
ages 1 and 2 shount of Health and Note: If item 27 is not other traumatic	-	20a. Method of Disposit		brothe	×	20h Place		ion (Name of cerr	netery I	77 F	ate /	20c. Location - C	ity or Town, State	-
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Baltimore, permit. Pages 1 a Department of He Important: If ite		21. Sig war 15 ovir unera	il beryse Licen	sce /	1		22. Na	me and Address	CLL Cility		11		Jessup PA	۱
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Physician /Medical		failure. List only o	ne cause on ea	ach line.									Between Onset a Death	and
xaminer		Immediate Cause (Fina or condition resulting in		Hyper Due to (or as			eros	clerotic	care	diova	scular	disease		-
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	<u>ا</u> ه	Sequentially list conditi if any, leading to immed		Due to (or as	a consequ	ence of):								
·	[	cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) last  Due to (or as a consequence of):												
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760, cate be ex physician the burial	Medical	IF FEMALE:				of pregnancy	,					23d. Date of d	elivery	
876 tifical ng ph as the		23b. Was decedent preg past 12 months?	gnant in the		birth		_	al death 3	Ectopic	c pregnancy	У	Month	Day Year	
Box 687  • death certifithe attending ed for use as t	sician		9 Unknow		gnant at tim	e of death	5 Oth	er (Specify)						
BC ne dea	21	Part II. Other significa		9 0116	nown	it not rocultin	an in the u	nderlying cause o	iven in Pa	art I	23e. Did tob	acco use contrib	ute to the cause of death?	?
P.O. Bc that the der med by the	2			contributing	to death bi	it not resulti	ig in the u	inderlying cause g	JIVCII III I C	21(1.			Probably 4 V Unknow	
S, P.C	8	Alcohol	L use								24a. Was a		ere autopsy findings avail	
cords, law requir has been s 2 should b	흺					_					autops perforr	y pri	ior to completion of cause eath?	of
Rec The la	Completed										1 <b>V</b> Yes 2		Yes 2 No	)
	Be C	25. Was case referred examiner?		Hannital:					of Death	(Check on			101	
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or Attendant death Director:	띭	3 Suicide 6	Could not	be		y - At home,	farm, stree	et, factory, office t	ouilding, et	tc. 28	or Town, St		r or Rural Route Number,	City
Spital lours :	Certification:	4 Homicide	determine							10				_
To the Hospital within 24 hours To the Funeral completely filled		29a. Certifier (Check only one) 2 Me	rtifying Physic	ian: To the b	est of my k	nowledge, d nation and/or	eath occur	red at the time, d ion, in my opinior	ate and pla n, death oc	lace, and di ccurred at t	ue to the cause he time, date a	e(s) and manner a and place, and du	ue to the cause(s)	
To the within To the Comp	Medical	29b. Signature and title		and manne	r stated.			29c. Licens					ed (Month, Day, Year)	
	2	29D. Signature and title	, or certifici	0/11	c 0				M.E.			June 29, 20	009	
		- Ca	1 oc	nul	Va	th (lt oo								
Ø,/	1	30. Name and address Carol Allan, M		completed co ant Medica				Street, Baltim	ore. ME	21201				
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Registr	rar	31. Date filed (Month, I	JL TO 2	2009	Cline	N B	1	aked						
DHMH 17 Rev 1/200	01			2		O	RIGINA							

		-	amend #5 Per FH Garage	E OV IVREU YIZI I	u≠ Depa Cer	rtificate of L	Death		eg. No.	22002	
			1. Decedent's Name (First, Middle, Last)					2. Date of Deat	h Day Year	3. Time of Death	
	Physicia /Medic		Curtis	D.	Mor	ris		July	8, 2009	7:35 A <sup>M</sup>	
	Examin		4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Location of Death			4c. County of Death		
gray all a			163 Ellen Avenue		last birthday)	Severn  hday) If Under 1 Year   If Under 24 Hrs. 8.			Anne Arundel  9. Birthplace (State or Foreign Country)		
	Funeral Director								9. Bi 26,1957	LA LA	
	w w	Director	Usual Residence of Decedent  10a. State 10b. County	10c, Cit	v. Town or Lo	cation				10d. Inside City Limits	
	Marylk		Maryland Anne Arunde	1 Co.	Severn	ı				1 ☐ Yes 2 No	
	r 28a		10e. Street and Number			10f. Zip Code		1	0g. Citizen of What C		
	th with	ral D	163 Ellen Avenue				21144		United		
	tems	Funeral	11. Marital Status 12. Was	Armed Forces;		U.S. 13. Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican, 6					
330	rs afte	by F	If Ye	s, Give r or Dates:	-	l∐Yes 2∭Mo	Specify:		Specify:	White	
9500-61212	be filed within 72 hours after death with the Maryland that Hygiene.  Id other than "natural", or items 23a or 28a-f show event, the Medical Evarriner must be rediffed at	ted	15. Decedent's Education (Specify only highest grade comp.	ated)	16a. Deced	dent's Usual Occup	ation	na I	16b. Kind of Busines	s/Industry	
Ž	ithin 7 ne. han "r	Completed		ege (1-4or 5+)	1		during most of workii f)		Religi	on	
7	iled w Hygie ther ti nt, in		17. Father's Name (First, Middle, Last)	6 +	MI	nister_	18. Mother's Name	(First, Middle, I		OII	
ă	be od o	To Be	Halbert Morris			Alma Wallace					
Maryland	s 1 and 2 should be f f Health and Mental I item 27 is marked of other traumatic eve		19a. Informant's Name/Relationship (Type. Prin	t)	19b. Mailir	ng Address (Street	and Number or Rura	al Route Numbe	r, City or Town, State	, Zip Code)	
Σ,				ife		Ellen Ave			yland 211		
galtimore,	ges 1 It of H If itel		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Remova			sition (Name of natory or other place			20c. Location - City o		
	it. Partruction of the property of the propert		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral 8 stylice Licensee	At		Cremato  Name and Addre				e, Maryland	
g	permit. Pages 1 and Department of Heal Important: If item 2 any injury or other ODCE.		21. Signature of 1 dileng delivices series	/ M0112	o 1		51n		Funeral &		
	Physician /Medical Examiner		PMOTIZI Services PA: 1 2nd Ave. SW Glen Burnie, MD 21061  23a. Part 1. Enter the disease, or compositions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only no cause on each line.  Approximate interval Between Onset and Death								
		er	Immediate Cause (Final disease or condition metasthic panteance cancer 6/2037								
and a			resulting in death)	ue to (or as a conseq	uence of):						
			Sequentially list conditions, b.	ue to for es a nonseo	to for eally consequence off:						
		Examiner	Sequentially list conditions, if any, leading to in investigate cause. Enter Underlying Cause (Disease or injury that initiated events c								
oʻ	e exec an an	Exa	resulting in death) Last			uence of):					
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ROX	death a atter d for u	Physician/M	in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopi 4 Pregnant at time of death 5 Other				ctopic pregnancy Other (specify)		Month Day Year		
л О	tt the (by the tached	hys	9 ☐ Unknown	Unknown				I	41.00		
	The law requires that the death cer ate has been signed by the attendir bage 2 should be detached for use	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown			
Records,	requi	eted						24a, Was a		autopsy findings available	
ž	sician: The law certificate has t irector, page 2 s	Completed						autop perfor	autopsy prior to completion of cause of death?		
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<u>≥</u>	al or A s after I Dire	erti	4 Homicide determined building, etc. (Specify)								
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director, p.	Medical C	29a. Certifier (Check only (Ch								
	the lithin 2 the lothel		one) and manner stated.  29b. Signature and tible of certifier			29c. Licens	29c. License number 29d.			. Date signed (Month, Day, Year)	
	FSFö		No Jakem, 1	MD		DS	3070		July 9,	2008	
	10	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  1650 07/18515 St BG/t, MD 2/271 Den Cahern									
	Sta		31. Date filed (Month, Day, Year) 32. Report & Signature  JUL 10 2009 June 18. Sand								
	Registr	લા	JUL 1 (1 2009	Elnen	13. 1	Barre					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-05267 State of Maryland / Department of Health and Mental Hygiene Gregory Joseph Marsh 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle,Last) Physician/ July 4, 2009 1621 hrs Medical Examiner 61E6014 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) 409 South Highland Avenue If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** Months Days Hours Min. 5 Director 0 742038 Yrs 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10b County 10a. State Yes 2 No Directo 10g. Citizen of What Country 10e. Street and Number 602 14. Race - American Indian, Black, Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 1 Never Married 2 Armed Forces? Married 2 Yes, Give Year 2 No specify: Widowed Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner by 16b Kind of Business/Industr 16a. Decedent's Usual Occupation (Give kind of work done Pages 1 and 2 should be filed within 72 hours nent of Health and Mental Hygiene. 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 6 17. Father's Name (First, Middle, Last) EDWARD HAMES Be 19a. Informant's Name/Relationship (Type, Print ) 5 . 5 . FA 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State Nonation 5 Other Specify. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Approximate Interval caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 23a. Part I. Enter the disease, or complications that **Physician** Between Onset and failure. List only one cause on each line /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Physician/Medical 23a,27,perME, g893 7/22/09 TT X UNPENDED AMENDED the attending physician ed for use as the burial -The law requires that the death certificate be Division of Vital Records, P.O. Box 68760, 23d Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 3b. Was decedent pregnant in the Month Day 3 Ectopic pregnancy Live birth past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 Yes 2 No 3 Probably 4 V Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy death? After this certificate has performed Yes 2 V No No To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certificompletely filled in by the funeral director, i 26 Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Inpatient 2 Nursing Home 5 Residence 6 ✔ Other: Scene DOA ER/Outpatient 3 1 Yes 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 1 X Natural 1 Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Registrar DHMH 17 Rev 1/2001

OCME 2006

and manner stated

Assistant Medical Examiner

32. Registrar's Sgnature

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifier

Ana Rubio MD.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

July 9, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 20b&c ref FH 8893 7/10/09 TT State of Maryland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 67620 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner manyland medialopte Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercises must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Nes 2 No **Funeral Director** BALTI MORE 10g. Citizen of What Country? 10e. Street and Number U.S.A Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 No Specify: þ Black 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TECH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NZLLIAM ഉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposit cemetery, crema Western 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 12009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility / 3EVIRLY 2. CROMPETE 154 21. Signature of Funeral Service License 2700 Edmandson AUE-Approximate Interval Between Onset and Death 23a. Parvi. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** 54 cuentially set our allians if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 ☐ Yo
9 ☐ Unknown Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by funeral director, page 2 should be 2 🗌 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 25. Was case referr o medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jolepalen, MO

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

1. 10 2009 Server S. parket

32. Registrar's Signature

ORIGINAL

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Meadows 10:10 P.M Nettie Elaine 2009 Ju1y /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5609 Sandy Bluff Way Baltimore Anne Arundel Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 □ M 2 🖾 F 435 86 7092 59 Alabama Director 02/12/1950 Usual Residence of Decedent 10d. Inside City Limits show 10a. State 10c. City, Town or Location th and Mental Hygiene. ?? is marked other than "natural", or items 23a or 28a-1 shov traumatic event, the "Medical Examinar must be notified at 1 ☐ Yes 21 No Director Anne Arundel Baltimore Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the N Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature" any injury or other traumatin more...... the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5609 Sandy Bluff Way 21225 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify: ≥ 3 Widowed 4 X Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerical Worker Legg Mason 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Leland Yarbrough Betty Louise Scott 0 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Wright / Daughter 5609 Sandy Bluff Way Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State Bayview Crematory, Inc.07/07/2009 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 selle 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin Onset and Death Immediate Cause (Final disease or condition resulting in death) 800,50 **Physician** ins /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month in the past 12 months? Day Year 4 Pregnant at time of death 9 Unknown 5 Other (specify) signed by the a d be detached f ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ₽ MO 1 🗌 Yes 3 Probably 4 Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 1 □Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie ME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), 31. Date filed (Month, Day, 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 4:30 P. M Mares Lisa 2009 Ju1v /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore 2257 Searles Road Dunda1k If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Months 40 Director 218 88 6155 09/12/1968 <u>Maryland</u> Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐Yes 2 🕱 No Director Dunda1k Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21222 U.S.A. 2257 Searles Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 XNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 □Yes 2 🛣 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: 2 White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Caretaker Nursing Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Standiford Joan Mitchell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2.
Department of Health an.
Important: If item 27 is m. any injury or other 2257 Searles Road Dundalk, Maryland 21222 Rigo Mares / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 07/10/2009 | Baltimore, Maryland Bavview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or heart failure. 4001 Ritchie Highway domplications that caused the death. Do not enter the mode of dying, only one cause on each line. Approximate Interval Between Onset and Death such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) ue to (or as a consequence of): /Medical Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year Day 5 Other (specify) ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 D nknown Completed 24b Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 🗖 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ER/Outpatient 3 DOA 2 🗆 1 Inpatient 6 ☐ Other (Specify) 27. Manner 28d. Describe how injury occurred Certification:

Examiner burial-transi and Box 68760, attending physician certificate be the as been signed by the atte should be detached for t Ö نه Division of Vital Records, To the Hospital or Attending Pwithin 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral

After

28a-f show

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or items 23a

"natural",

is marked other than

2 should be fi and Mental F

Baltimore, Maryland 21215-0036

the Medical Examiner must be notified at

5 Pending investigation 1 tural 2 ☐ Accident

6 □ Could not be 3 Suicide determined 4 Homicide

28a. Date of Injury (Month, Day, Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Medical

and manner stated. 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) July 9, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anil Uberoi (Month, Day, Year)

JUL 1 0 2009

32. Registrar's Signature

4419 Falls Road

Baltimore, Maryland 21211

State Registrar

Registrar

State

30. Name and

31. Date filed (Month, Day, Year)

JUL 1 0 2009

Id Court Road Randal Istown MD

address of person who completed cause of death (Item 23a) (Type, Print)

Buter

2. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 8 Day 2009 Gilbert 01en Nutter 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Burnie Anne Arundel Glen Burnit Itimore Washington Medical Center 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number Year) Months Days Hours 1 M 2 □ F 62 235-70-7971 Oct. 1946 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 🔯 No Maryland Anne Arundel Co. Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f Zip Code 21060 United States 205 Nina Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No 11. Marital Status 1 MYes 2 No If Yes, Give Vietnam Year or Dates: 1 ☐ Never Married 2 Married 1 □Yes 2 🙀 No Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Welder Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Fern Bel1 01en Silbern Nutter Caro1 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Patricia Nutter / Wife 205 Nina Court Glen Burnie, Maryland 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 07/09/2009 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Ser Services PA, 1 2nd Ave SW; Glen Burnie, MD 21061 M01121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death We Immediate Cause (Final hronic disease or condition resulting in death) Due to (or as a consequence of): eum onia Secure fielly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) 9 | Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 1 No 1 ☐ Yes 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes, 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manuar of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending

Physician /Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

Funeral Director

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Completed

Be

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventinar must be recitied at once.

Nutter Gilber

Baltimore, Maryland 21215-0036

been signed by the should be detached certificate has birector, page 2 sl

Exam Physician/Medical δ Completed Be Certification: To

After this certific funeral director, within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

2 Accident 3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injury building, etc. (
29a. Certifier	1 Certifying Phys	Iclan: To the best of r

1 ☐ Yes 2 ☐ No At home, farm, street, factory, office (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2☐ Medical Exa	miner: On the basis and manner		nation and/or investig	ation, in my opinion, death occ	curred at the time, date and place, and due to the caus
title of certifier	2 11)	0.	T. M.D.	29c. License number	29d. Date signed (Month, Day, Yea.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive, Glen Burnie, MD. 301 WOSPITED Drive, Glen Burnie, MD. Year)

31. Date filed (Month, Day, State Registrar

(Check only

29b. Signature and title of certifier



Parko

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 07/03/2009 4:07a M Verna R. Norris /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Towson Gilchrist GBMC Hospice If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 □ M 2 🔀 F Yrs MD 09/10/1956 Director 21**7-74-**6227 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location f show d other than "natural", or items 23a or 28a-f showevent, the Medical Examiner must be notified at 1 X Yes 2 □ No Director Baltimore MD na 10g. Citizen of What Country? 10e. Street and Number USA 21211 4110 Evans Chapel Road Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify. \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Schools secretary 12th permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygii Important: If Item 27 is marked other any injury or other traumatic event, III 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alma Green William V. Norris, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1004 W. 42nd Street Baltimore, MD Shirley Milledge Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/9/09 Baltimore, MD Metro Crematory 22. Name and Address of Facility 4300 Wabash Avenue 21 Signature of Funeral Service Licens Shan March FH West Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER RK **Physician** disease or condition resulting in death) /Medical Due to (or as a constituence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical attending physic for use as the b 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) signed by the a Ö 9 🗆 Unknown 9 HInknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has l irector, page 2 s autopsy performed' 2 🗆 No 1 ☐ Yes 2 ☑ No 1 Yes Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) Certification: To of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar 30. Nama an

31. Date filed (Month, Day,

Year)

DHMH 17 Rev 1/2001

N. Charley St. Balto, Md 21205

address of person who completed cause of detail (Jem 23a) (Type, Print)

Some

22. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** a M 2009 4:15 July Irona E. Pope /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Gilcrest Hospice Baltimore Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days 69 1 □ M 2 ⋤ F Yrs 213-36-7497 Director 3/30/40 MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it e Marical Examinant be notified at gones. Once. 1 ☐ Yes 2 X No **Funeral Director** N/A Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 5301 Carter Avenue 21214 USA Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status African 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: <u>۾</u> 3 □ Widowed 4 □ Divorced American Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) City of Baltimore Liaison Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be walter Lee Irene Victoria Lee ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5301 Carter Avenue, Balt., MD 21214 Irona Thompson/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/15/09 Carmel Cem Balt., MD 22. Name and Address of Facility Hari P. Close F. 21. Signature of Funeral Service Lives ee Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final week 5 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner elk. 4 Sequentially list conditions, if any leading to infried at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed and -tran Due to (or as a consequence of): burialattending physician for use as the buria Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1, □ Yes 2 □ No 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Dav 5 ☐ Other (specify) signed by the a P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? death but not resulting in the underlying cause given in Part I. Records, \$ 2 No 3 Probably 4 Unknown 1 Tes Completed peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy or Attending Physician: The certificate 1 ☐Yes 2 ☐No 2 No 1 Yes of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this ို After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No ithin 24 hours after death.

the Funeral Director: A suppletely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and little of certifier 2 Clarker ST. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 6-6 31. Date filed (Month, Day, Year) State Registrar 1 0 2009

DHMH 17 Rev 1/2001

<b>Physician</b>
/Medical
Examiner

**Funeral** 

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 Is merked other than "natural", or items 23a or 28a-f show eny injury or other traumetic event, it is Modical Examine must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit

	For State Of Maryland  State Registrar		rtificate of			Reg. No. 20	09 22041			
	1. Decedent's Name (First, Middle, Last)				2. Date of Dea		3. Time of Death			
n	SAM PERLIS				06	22 2	009 20 10 M			
r	4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	Location of Death		4c. County of				
	Washington Adventist Hospital 5. Social Security Number   6. Sex   7. Age (In yrs. I	ast birthday)	If Under 1 Year	a Park If Under 24 Hrs.	8. Date of Birt (Month, Da		gomery 9. Britishace (State or Foreign			
	349-07-5666	Yrs.	Months Days	Hours Min.	Apr. 1	8, 1913	Country) Illinois			
		y, Town or Lo	cation				10d. Inside City Limits			
ក្ត	MD Prince Georges Hya	ttsvil	10				1 □ Yes 2 🏝 No			
<u>မ</u>	10e. Street and Number	CCSVII	10f. Zip Code			10g. Citizen of Wh	nat Country?			
<u>ا</u> ع	5821 Queens Chapel Road		20782			USA				
Dec	11. Marital Status 12. Was Decedent Ever in U. Armed Forces?	S. 13. V	Was Decedent of H	lispanic Origin? (S	pecify Yes or No	14. Race	- American Indian, White, etc.			
Completed by Funeral Director	1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No 1 ☒ Widowed 4 □ Divorced Year or Dates:		1 □ Yes 2X No	Specify:	Trican, Go.,		White			
ited	15. Decedent's Education (Specify only highest grade completed)		dent's Usual Occup		kina I	16b. Kind of Bus	iness/industry			
npie	Elementary/Secondary (0-12) College (1-4or 5+)	`life. L	DO NOT use retire	d) "	ung					
3	5+	Mathe	matics P		(Cinch Mindella	Educa Maiden Surname				
g	17. Father's Name (First, Middle, Last) Adolf Perlis			Ida Zis		ivialueri Surname	,			
2	19a. Informant's Name/Relationship (Type. Print)	10h Mailin	na Addrona (Ctroot			or City or Town S	State Zin Code)			
	Robert Perlis - Son	183	ng Address <i>(Street</i> 3 Clover on Rouge	dale Ayer	ue 108	er, only or rown, c	rate, zip code,			
- 2			sition (Name of natory or other place		Date		City or Town, State			
	1 Li Burial 2 Li Cremation 3 Li Removal from State	ience	Care	6-25	-2009	Aurora, CO				
	21. Signature of Funeral Service Licensee		2. Name and Address				80011			
	3a. Brit1. Inter the disease, or complications that caused the death						Approximate Interval Between			
	shock, I r heart failure. List only one cause on each line. Immediate Cause (Final	Line	, bout				Onset and Death			
	disease or condition resulting in death)  Due to (or as a consequence of):									
	Sequentially list conditions b.	/								
ner	if any leading to immediate Due to (or as a consequence. Enter Underlying	uence of):								
Eam	Cause (Disease or injury that initiated events c.									
ב ה	resulting in death) Last . Due to (or as a consequence of the conseque	uence on:								
edical Examiner	d									
	IF FEMALE: 23c. If yes, outcome of pregna	incy				23d Date	of delivery			
nysician/lv	in the past 12 months?	Ideath 3	☐ Ectopic pregnand ☐ Other (specify) _	у		Mon				
l S	1 Yes 2 No 9 Unknown 9 Unknown		,,,,,,							
S Z	Part II. Other significant conditions contributing to death but not rest	ulting in the u	nderlying cause gi	en in Part I.	23e. Did t	obacco use contri	bute to the cause of death?			
D .	I neumania				1 🗆	Yes 2 No :	3 Probably 4 ⊕ Hiknown			
Completed					24a. Was	an 24b. W	/ere autopsy findings available rior to completion of cause of			
é					perfo	rmed? _ de	eath? □Yes 2□No			
D D	25. Was case referred to medical examiner?			26. Place of Dea		one)				
0	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3□ DOA Oti	ner: 4  Nursing H		dence 6 ☐Othe	· · · · · · · · · · · · · · · · · · ·			
HOI:	27. Manner of Death  1	28b. Time of Injury	Wo	ryat k? ∐Yes 2 ∐No	28d. Describe	how injury occurre	ed			
IICa	3 ☐ Suicide 6 ☐ Could not be 28e, Place of Injury - At ho	me, farm, str			28f. Location (	Street and Numbe	er or Rural Route Number,			
Ser	4 ☐ Homicide determined building, etc. (Specif	y) 			City or To	wn, State)				
Medical Certification:	29a. Certifier 1	wledge, deat ition and/or in	th occurred at the to restigation, in my	ime, date and plac opinion, death occi	e, and due to the urred at the time,	cause(s) and ma date and place, a	nner as stated. and due to the cause(s)			
Me	29b. Signature and title of certifler		29c. Licen	se number			(Month, Day, Year)			
	Salujusaile lan, MD		Do	065703		06/3	24/09			
	30. Name and address of person who completed cause of death (Item	n 23a) (Type,	Print)	OU CHE	LOLL A	VENDI	20012			
	SAGUSALUS WAR  31. Date filed (Month, Day, Year)  32. Begistrar's Signa	iture	TI	moun	PARK	, MD	20412			
е	31. Date filed (Month, Day, Year) 32. Fegistrar's Signal	4	1.00							

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.... 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7:50 F. Albert Praley wh 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Days Hours Min 1 X M 2 □ F 214-24-7864 80 Usual Residence of Decedent 10d. Inside City Limits 10h. County 10c. City. Town or Location 1 ☐ Yes 2 TNo Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 302 Canterbury Court 21061 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 1 Ñ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel Elementary/Secondary (0-12) College (1-4or 5+) Court System District Court Commissioner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frank J. Praley Augusta Wimmer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs Reva Norwig/Companion 302 Canterbury Court Glen Burnie, MD 21061 July Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park 2009 Glen Burnie, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Crema ure of Funeral Service Licenses Services PA 1 2nd Ave. Glen Burnie, MD 21061 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (w as a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23d. Date of delivery Month Day Year

**Physician** /Medical Examiner

**Physician** 

/Medical

10a. State

MD

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Event is a must be notified at any Injury or other traumatic event, the Medical Event is a must be notified at any once.

Examiner edical

attending physician and for use as the burial-tran signed by the a d be detached for director,

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Certification:

Medical

To the Hospital or Attending Physiclan: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	
Part II. Other significant condition	is contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco u  1  Yes 2  24a. Was an autopsy performed?

e given in Part I.	23e. Did tobacco use contribute to the cause of death?							
	1 ☐ Yes 2 ¥ No 3 ☐ Probably 4 ☐ Unknown							
	24a. Was an autopsy performed?  1 ☐ Yes 2 ☐ No  24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No							
26. Place of Dea	th (Check only one)							
Other: 4 Nursing H	ome 5 ☐ Residence 6 ☐ Other (Specify)							
Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred							
ice	28f. Location (Street and Number or Rural Route Number, City or Town, State)							

29d. Date signed (Month, Day, Year)

	3 ☐ Suicide 4 ☐ Homicid
29a	. Certifier (Check only
	ana)

27. Manner of De

1 Natural 2 Accident

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License numbe

28c. Injury at Work?

29b. Signa	ture and title of certifier
	A
	12212
· ·	TOMMO

5 Pending investigation

6 ☐ Could not be

25. Was case referred to medical examiner?

1 Yes 2 No

(Item, 23a) (Type, Print)

2 ER/Outpatient 3 DOA

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

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State Registrar

epital: 1 Inpatient 2 | 28a. Date of Injury (Month, Day, Year)

24 hours a

within 24 hor To the Fune completely fi

State of Maryland / Department of Health and Mental Hygiene rgiene Reg. No. 2009 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 7:51 AM 07 07 09 George M. Patzschke /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GOOD SAMARITAN HOSP BALTIMORE, MD If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑** M 2□ F 80 Director 09/24/1928 Maryland 212-24-8551 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show other traumatic event. I'm Medical Examiner is ust be notified at 1 ☐ Yes 2 No Baltimore Parkville MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 0 2613 Wendover Road 21234 U.S.A. items 23a Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1XDYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 ☐ Married ö 1 ☐Yes 2 No Specify. Specify: White þ 3 Widowed 4 Divorced "naturai" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Fire Communications 12 18. Mother's Name (First, Middle, Maiden Surname) aryland 17. Father's Name (First, Middle, Last) Be Mental and 2 should be of Health and Ments Item 27 is marked Emma Marks George Patzschke 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2613 Wendover Road, Parkville, MD 2234 Mary Patzschke/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral
Chapel Bel Air Ġ. 20c. Location - City or Town, State permit. Pages 1:8 Department of He Important: If iten any injury or oth 20a. Method of Disposition imor 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, MD 22. Name and Address of Facility
Evans Funeral Charel & Cremation Services 23a. Part1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Signature of Funeral Service Licensee 8800 Harford Road, Parkville, MD 21234 Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA **Physician** DAYS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner AUD FAST BACILLI BACTEREMIA DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit BCG INSTALLATION FOR BLADDER CA MONTHS Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🔲 Ectopic pregnancy Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð HTN, DYSLIPIDAEMIA, BLADDER CA, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? CORONARY ARTERY DISEASE WITH CABG 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 07/07/2009 , MD **RES** 000 14+1 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who 40 GOOD SAMARITAN HOSP, BALTIMORE, MD LUTCHMANSINGH DENUSE egistrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-04923 State of Maryland / Department of Health and Mental Hygiene Marshall Phillips 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day June 22, 2009 0221 hrs Medical Examiner Marshall В. Phillips 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince Georges Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MWDD/YYYY) 9. Birthplace (State or Foreign NOrth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Director 04/14/1950 courcarolina 578-70-7994 59 1 X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 XYes 2 No 28a-f show MD Prince Georges Landover Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f she notified at once. Director 10g. Citizen of What Country? 10e. Street and Number 7806 Sheriff Road 20785 USA 14. Race - American Indian, Black, 11 Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 2 X Married Never Married Yes Black Divorced If Yes, Give Year Yes 2 X No specify: Specify: event, the Medical Examiner ģ 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ 21215-0036 12th Dietician Private Industry 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ola Phillips Cassie Baker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 Thomasine G. Phillips/Wife 7806 Sheriff Road, Landover, MD 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, Burial 2 X Cremation 3 Removal from State crematory or other place Riverdale Crematory 7/3/09 Riverdale, MD Donation 5 Other Specify 22. Name and Address of FacilityAustin Royster Funeral Home 21. Signature of Funeral Service License M00996 3821 14th Street, NW, Washington, DC 20011 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Hypertensive Cardiovascular Disease Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and or use as the bunal - transit Physician/Medical AMENDED UNPENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth 3 Ectopic pregnancy Month Day Fetal death 2 past 12 months Pregnant at time of death 5 Other (Specify for 1 Yes 2 No 9 Unknown Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ģ No 3 Probably 4 ✔ Unknown Yes 2 Metastatic Carcinoma Completed page 2 should 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of this certificate has death' performed' 1 🗸 Yes 2 1 V Yes 2 No the Hospital or Attending Physician: thin 24 hours after death. the Funeral Director: After this certifi 26.Place of Death (Check only one funeral director, 25. Was case referred to medical Be Other<sub>4</sub> Hospital: 1 Inpatient 2 V ER/Outpatient 3 Residence 6 DOA Nursing Home 5 1 ✔ Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work' 28d. Describe how injury occurred 27. Manner of Death Certification: 1 V Natural Yes 2 Pending the Investigation Accident 28f. Location (Street and Number or Rural Route Number, City filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) determined (Specify) Homicide 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number June 22, 2009 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) 3 Patricia Aronica-Pollak MD. 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner 31. Date filed (Marti. 2 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 OCME 2006

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Robin Yvette Plumley 8:39 аМ 2009 July 3, 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Anne Arundel 603 Queenstown Road Severn If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 11,1955 Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In yrs. last birthday) Months Days Hours Min. 1 □ M 2 🔀 F 54 215-66-8196 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County Anne Arundel Severn 1 ☐ Yes 21734No 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21144 USA 603 Queenstown Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 255No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 □Yes 2√ If Yes, Give Year or Dates: 1 Never Married 2 Married white 1 ☐ Yes 2 🛣 No Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hazel Charlene Bishop Lowell Chester Edens 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carl R. Plumley / Husband 603 Queenstown Road, Severn, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition July 8, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Burtonsville, MD Union Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Donaldson Funeral Home, P.A. J. Ken Stiles M01053 313 Talbott Ave., Laurel, MD 20707 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final erchae disease or condition resulting in death) Due to (or a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence o Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 ∐Yes 2 No 9 ☐ Unknown in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Hoknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ 60 24a, Was an autopsy performed? Yes 2 No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

**Physician** /Medical Examiner Examine The law requires that the death certificate be executed

Department of Health Important: If Item 27 any Injury or other trong once.

Physician

/Medical

Examiner

10a, State

MD

Director

Funeral

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Completed

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**Funeral** 

Director

show

of Health and Mental Hygiene.
Item 27 Is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at

the Maryland

death with

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

burial-tran physician the burial Physician/Medical as attending use ate has been signed by the atte page 2 should be detached for i ģ Completed Be

P.O. Box 68760,

Division of Vital Records,

certificate e Hospital or Attending Physician: 3 24 hours after death. • Funeral Director: After this certifica letely filled in by the funeral director, p

၉

Certification:

Medical

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a, Certifier

4 Homicide

29b. Signature and title of certifier

JUL

completely filled To the I within 2 To the I

State Registrar

hord 31. Date filed (Month, Day, Year)

5 Pending investigation

6 ☐ Could not be

cause of death (Item 23a) 30. Name and address of person who completed

28a. Date of Injury (Month, Day, Year)

end manner stated.

-noli's

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

28b. Time of Injury

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 🦾 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month July Physician Year Stella Raimondi 29PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Randallstown Seasons Hospice If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Feb. 6, 1920 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Maryland 1 ☐ M 2 🖫 F 89 218-03-0878 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show traumatic event, the Medical Examiner must be notified at MD Baltimore Baltimore Funeral Director 1 ☐ Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Medical Everniner roust be no once. 21208 United States 725 Mount Wilson Lane, Act. 524 12. Was Decedent Ever in U.S. Armed Forces?

1 
Yes 2 
No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: White <u>ک</u> Specify: 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Raimondi's Florist Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Anoin Louis Arpin ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3387 Jeffrey Lori South Drive, Finksburg, MD. 21048 Paul Raimondi Jr. - Son 20b. Place of Disposition (Name of cemetery, crematory or other place)

Most Holy Redeamer Ju

Cemetery

22. Name and Address of Facility 20a. Method of Disposition Date 20c. Location - City or Town, State XBurial 2 Cremation 3 Removal from State July 11,2009 Baltimore, Maryland 4 Donation 5 DOther (Specify) 21. Signature of Funeral Service Licenser Evans Funeral Chapel & Cremation Services - Parkville 8800 Harford Road Parkville, Maryland 21234 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if only hading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a c onse lue or Attending Physician: The law requires that the death certificate be executed attending physiclan and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 DOther (Specify) 110 SPCE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 ☐ Pending investigation 1 Natural To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

10

State Registrar

29b. Signature and title of certifier

31. Date filed (Mont)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year

Burton

29c. License number

H45931

2835 Sin 1th Avonus Svite 200 Baltimore MO

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Me	ai yiaiiu /		tificate of	Death		-	. 20	009	220	)47
	Physici	an	1. Decedent's Name (First, Middle, La		D 1 '				Date of Dea     Month		ě,	Year 2009	3. Time of De	
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	Funeral		Social Security Number 6. 8	Sex 7. Age	e (In yrs. last b	oirthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day			9. Birth	± y nplace (State or F intry)	Foreign
	Director		163-26-2686	<b>△</b> M 2□F	75	Yrs.	Months Days	Hours Min.	Aug 2,	19	33		nsylvan	ia
	and w		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location										10d. Inside City	Limits
	Mary I-f she	ţō	MD Anne Aru	undel	Hanov	er							1 <b>⊠</b> Yes 2	□No
	or 282	Direc	10e. Street and Number 10f. Zip Code 10g. Citizen of What							What Cou	intry?			
	ath wi	Funeral Director	1911 Pometacom Drive 21076  USA  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Flican, etc.)  14. Race - An High Research of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Flican, etc.)											
	items	ū	11. Marital Status 1 ☐ Never Married 2 ☒ Married	12. Was Decedent B Armed Forces? 1 ⊠Yes 2 □ N		13. W	as Decedent of F Yes, specify Cuba	fispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)		Blac	ck, White,	etc.	
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Baltimore, Maryland	ald be fental rked c	To Be	James Ambrose H	Robinson				G. Mer	rel Phi	11i	ps			
ā	2 shou and N is ma	-	19a. Informant's Name/Relationship (	, ,				and Number or Run						
S o`	and 2 health m 27 her tr		Ana Maria Robinso	on /spouse				m Dr., Ha						
ב פ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, It a Mariest Exprise Land 1 a rottled at once.		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐				ition (Name of atory or other place		Date			•	y or Town, State	
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S 0	ttendi Jeath. tor: A the fu	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b			F		Yes 2□No	20/ 1 (5					
DIVISION	after of Al	Certification:	4 ☐ Homic¹de determined	28e. Place of Inju- building, etc	c. (Specify)	rarm, stree	et, factory, office		City or Tow			er or Hui	ral Route Numbe	er,
	spital hours neral y filled			nysician: To the best										
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	Vith Vith Com	Σ	29b. Signature and title of pertifier	0.41	- ^	6.	29c. Licens	se number	1	29d. D	ate signe	d (Month	, Day, Year)	
j	7+1		M	1-1000	r /	VV	D273	66			1/8	10	7	
1	21		30. Name and address of person who Arvind M. Mehta,	·	,	, , , , .	,	9. Colled	e Park	MD	207	40		
	Sta	te	31 Date filed (Month Day Year)	32 Registra	r's Signature			,, 201109	- Luin,	1111	207			
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DHMH 17 Rev 1/2001

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Amend #26 perVerbal G893 7/10/09 TT

Amend #26 perverbal G893 7/10/09 TT

Dehartment of Health and Mental Hygiene

			For State Registrar	" State of Ma	aryland / L	•	rtificate of L			Reg. No. 2	9 22068
	Physicia	ın	1. Decedent's Name (First, Middle	Stanley	A Rozm	arv	nowski		2. Date of De Month July	Day Ye	
	/Medic Examin		4a. Facility Name (If not institution		n. Rozu	ici y		Location of Death	July	4c. County of D	
- () - ()		•	265 Long Point	Road				nsville			e Arundel
	Funeral Director		5. Social Security Number 213 28 9039	6. Sex 7. Ago	e (In yrs. last bir 79	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 11/15	rth ay, <i>Year)</i> 9. /1929 M	Birthplace (State or Foreign Country) laryland
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	n or Lo	cation				10d. Inside City Limits
	Marylined st	ţō	Maryland Ann	e Arundel	Cro	wns	ville				1 □Yes 2XINo
	or 28a	Director	10e. Street and Number		1		10f. Zip Code			10g. Citizen of What	
	ath wil		265 Long Poir					1032		U.S.A.	
36	72 hours after death with the Maryland "natural", or items 23a or 28a-f show vitcal Evaning must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent in Armed Forces?  ed 1 X Yes 2 □ in If Yes, Give Year or Dates:	No		Nas Decedent of H f Yes, specify Cuba I □Yes 2 <b>K</b> I No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecity Yes or No Rican, etc.)	5- 14. Race - A Black, W Specify:	merican Indian, Thite, etc. White
5-0036	e hour		15. Decedent	's Education		Dece	dent's Usual Occup	ation		16b. Kind of Busine	
	hin 72 ho e. an "natur Medical	Completed	(Specify only highes Elementary/Secondary (0-12)	t grade completed)  College (1-4or 5	5+)	life. L	kind of work done of OO NOT use retired	)	ing	<u> </u>	
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Mary	should nd Me mark matic	10	19a. Informant's Name/Relationsh							per, City or Town, Sta	te, Zip Code)
Ž.	and 2 salth a 27 is er trat		Mary Rozmaryno	owski / Wife	20	<b>6</b> 5 ]	Long Poin	t Road	Crowns		ryland 21032
aitimore,	Pages 1 s nent of He nt: If item ry or oth		20a. Method of Disposition  1   Burial 2 □ Cremation  4 □ Donation 5 □ Other (S)		1		sition (Name of natory or other place Veteran (	0 = 10	8/2009	20c. Location - City  Crownsvi	orTown, State
Balti	permit. Pages 1 and 2 should be f Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic evenonce.		21. Signature of Funeral Service	icensee	ushi	22	. Name and Addre	ss of Facility Go		neral Servi	ice, P.A. aryland 21225
			23a. Part1. Enter the disease, or shock, or heart failure. Life	complications that caused	the death. Do	not ent	er the mode of dyir	g, such as cardiac	or respiratory	arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_a	etas	ta		anel			Onset and Death
- Seam	/Medical Examiner		resulting in death)	Due to (or as	a consequence		neer				
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Ď,	ificate be executed physician and sthe burial-transit		resulting in death) Last	Due to (or as	a consequence	of):					
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. Box	death certi e attending id for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant a 9  Unknown	2 Fetal death		☐ Ectopic pregnanc ☐ Other <i>(specify)</i> _	у		23d. Date o Month	f delivery Day Year
7.	requires that the reen signed by th		Part II. Other significant condition	ons contributing to death b	ut not resulting i	n the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use contribu	te to the cause of death?
g	quires en sigr uld be	ed by							1 🗹	Yes 2□No 3[	Probably 4 ☐ Unknown
ပ္	e las has e 2	Completed							24a. Was auto perf 1 □ Yes	opsy prio dea	e autopsy findings available r to completion of cause of th? Yes 2 \sumbox
123	ysiclan: The is certificate director, pag	Be C	25. Was case referred to medical examiner?	1				26. Place of Dear			163 2 2 110
=	this al dii	၉	1 ☐ Yes 2 ☐ No		ent 2 ER/O	<u> </u>		4 LI Nuising I			Specify) HOSPICE
ב	ding Phys h. After this funeral dii	jou	27. Mann Death  1 1Natural 5 □ Pendin			Time of Injury	Worl	yat k? Yes 2 □ No	28d. Describe	how injury occurred	
DIVISION	deat deat ctor; y the	Certification:	2 Accident investig 3 Suicide 6 Could r 4 Homicide determ	not be 28e. Place of Inj	ury - At home, fa c. <i>(Specify)</i>	arm, str	eet, factory, office	ies Z III		(Street and Number o	or Rural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	edical Ce		g Physician: To the best Examiner: On the basis of and manner st	of examination ar						
	To the within To the comple	Mec	29b. Signature and title of certifier				29c. Licens	e number		29d. Date signed (M	fonth, Day, Year)
			Curt	5 Han	i, un	1	05	3306		7/4/0	9
			30. Name and address of person	who completed cause of c	death (Item 23a)	(Type,	Print)	- 2 - 0	Man	1.1.0 7.00	221101
	Sta	te ar	31. Date filed (Month, Day, Year)	2. Registr	rar's Signature	ba	that she	700	rnnaf	July My	1240/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 29d per phys. C893 7/10/09 dk
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1, Decedent's Name (First, Middle, Last) Day Month **Physician** Roulhac 29 2009 Tune /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore NUTSING atonsville HomE Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea. 5. Social Security Number 6. Sex **Funeral** Months 1 M 2 F Davs Hours Min. 21552487 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Importunet if fleath 27 is marked other than "natural" or harden. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Baltimore Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21229 USA 4803 Stafford Funeral 12. Was Decedent Ever in U.S. Armed Porces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1968 Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1□Yes 2☑No Specify: Specify: þ Black 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State of MD Iransportation Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Koulhac Blac Windell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Balto. MD 21229 Stafford Florine Freeman-Koulhac 54. 4803 Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State on Forest 7-7-09 Dwins Mills, MD 22. Name and Address of Facility Vaugha C. Greene Funeral Services 5151 Baltimore Na +11 Pike Balto. MD21229 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Waush C. Drees 5151 Baltimore Nk t'l Pil

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ROSTATE CANCER ETASTATIC Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed Due to (or as a consequence of): ر المجارك الم nding physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Donknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 2/ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2□ No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 28575 2009 30. Name and address of perspn who completed cause of death (Item 23a) (Type, Print) SmITH AVE SUITE 203 2835 AlCHAMI JASNEEM nn) 31. Date filed (Month Day, 32. Aegistrar's Signatur Year) Day, State Registrar

DHMH 17 Rev 1/2001

aiser Roberts	State of Maryland / Depart	tment of Health and Menta <i>ficate of Death</i>	al Hygiene Reg. N	2009 220
Physician/ Medical Examiner	Registrar  1. Decedent's Name (First, Middle,Last)  Kaiser Roberts		2. Date of Death Month Day July 6, 2009	3. Time of Death
)	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of		4c. County of Death
Funeral	University Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. las	Baltimore t birthday) If Under 1 Year   If Under	24Hrs. 8. Date of Birth (M	M/DD/YYYY) 9. Birthplace (State or Foreig
Director		2 Yrs. Months Days Hours	Min. 01/30/2	2007 Country) MS
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, T	own or Location		10d. Inside City Limits
Aaryland 28a-f show 1 at once	MS Clay Wes	t Point	1100.0	1 X Yes 2 No
n the Maryland 3a or 28a-f sh otified at once	836 East Broad Street	39773	,	United States
er death with to or items 23a r must be uot	11. Marital Status 1 X Never Married 2 Married Armed Forces?	. 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, I	n? ( Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
s after des rall', or i niner mu	1 Yes 2 X No 3 Widowed 4 Divorced of Pates:	1 Yes 2 X No specify:		Specify: White
2 hours "natur LExami	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)	16a. Decedent's Usual Occupation (Give ki during most of working life. DO NOT u	se retired)	b. Kind of Business/Industry
5-0036 cd within 72 hour lygiene. other than "natu he Medical Exan	0	Dependent	Name (First, Middle, Maid	Not Self Supporting
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica FO BE COMPIE	17. Father's Name (First, Middle, Last)  Brian Roberts		kole Kaiser	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-fsho injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	19a. Informant's Name/Relationship (Type, Print)  Brian Roberts, Father	19b. Mailing Address (Street and Numb 836 East Broad St		
re, W s 1 and 2 of Health of item 2 ner traus	20a. Method of Disposition 20b. Pl.	ace of Disposition (Name of cemetery, ematory or other place)	Date 20	Oc. Location - City or Town, State
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati	4 Donation 5 Other Specify:  21. Signature of Fun at al Service Licensee  T. Harman			West Point, MS
Ba permi Depa Impo	180	635 East Broad	Street, West	Point, MS 39773
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. I failure. List only one cause on each line.	Do not enter the mode of dying, such as ca		shock, or heart Approximate Interval Between Onset and Death
xaminer	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):		150	
ner	Sequentially list conditions, if any, leading to immediate cause. Litter Uncertying Cause			
d Siring distribution of the siring distribution	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of)	:		
execute ian and ial - tran	d.  AMENDED 23a,PII,	,27,permE, g896 10/2	23/09 TT	
b. Box 68760, the death certificate be executed by the attending physician and ched for use as the burial - transit  Physician/Medical Examiner	IF FEMALE: 23c. If yes, outcome of pregnation the 1 Live birth	The same of the same	pregnancy	23d. Date of delivery  Month Day Year
ox 68 sath certi attendin or use a	past 12 months?  4 Pregnant at time of dea  1 Yes 2 No 9 Unknown	2		,
O. B. at the de d by the stached f		sulting in the underlying cause given in Par		cco use contribute to the cause of death?
duires tha en signed uld be det ted by	Bicuspid aortic valve; impair	red postnatal lung	1 Yes	2 No 3 Probably 4 Unknown 124b. Were autopsy findings availab
Records, The law requires fricate has been sig	growth		autopsy performe	
tal Recian: The certifical ector, pa	25. Was case referred to medical	26.Place of Death (	Check only one)	
of Vit g Physia fter this neral dir	1 V Yes 2 No Inpatient 2 V I	ER/Outpatient 3 DOA Cirie 4  28b. Time of Injury 28c. Injury at Work		sidence 6 Other:
sion (strength death. ctor: A y the fur sation)	1 A Natural 5 Pending 2 Accident Investigation	1 Yes 2		A Number of Burel Boute Number Ci
Division or ital or Attending are after death. rat Director: After lied in by the funce led in by the funce ertification:	3 Suicide 6 Could not be determined (Specify)	me, farm, street, factory, office building, etc	or Town, State	eet and Number or Rural Route Number, Ci e)
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Medical Certification: To Be Completed by Physician/Medical Ex	20a Certifier	e, death occurred at the time, date and pla d/or investigation, in my opinion, death occ	ce, and due to the cause(s	) and manner as stated. d place, and due to the cause(s)
To To Com	and manner stated.  29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Month, Day, Year)
	My m	O.C.M.E.		July 7, 2009
	30. Name and address of person who completed cause of death (Item: Russell Alexander MD. Assistant Medical Exami		ore, MD 21201	
State Registra	1111	e have a		
DHMH 17 Rev 1/2001		ORIGINAL	OCME	

			For State	State o	f Marylan	•		Health and		0.0	09	22051
			Registrar			Cer	tificate of	Deam	2. Date of Deat	3	00	3. Time of Death
	Physicia		1. Decedent's Name (First, Middle, I Marion	R.		Swab			July 6		Year	1:10 PMM
1	/Medic Examin		4a. Facility Name (If not institution, g					or Location of Deat	h	4c. County Montg		7
	Funeral			. Sex 1 □ M 2 ☑ F	7. Age (In yrs. i		If Under 1 Year Months Days		8. Date of Birth (Month, Day, July 4,	Year)	9. Birthpl Count	ace (State or Foreign try) York
	Director		052-12-0807 Usual Residence of Decedent		88	Yrs.			July 4,	1921	New	IOLK
	how	_	10a. State 10b. County		10c. City	y, Town or Loc	cation				10	0d. Inside City Limits 1K∐Yes 2 □ No
1	28a-fs	Director	Maryland Montgo	nery	Ga	ithers	ourg 10f. Zip Code			0g. Citizen of V	What Count	
	a or 2		10e. Street and Number 301 Russell Aven	110			20877		'	U.S.A.		
	ms 23	Funeral	11. Marital Status	12. Was Dec	edent Ever in U.	S. 13. V		Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No-	14. Rac	e - Americ	
929	s i and z should be filed within 72 hours after death with the maryland. The than Mental Hygiene, tiem 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinational be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed For 1 ☐ Yes If Yes, Gi Year or D	2 🔀 No ve		Tes, specify ou		to mount oto.	Specify		
ָ ה	natura	Completed	15. Decedent's (Specify only highest to	Education grade completed)		16a. Deced	lent's Usual Occu	upation e during most of wo ed)	rking	16b. Kind of Bu	usiness/Ind	lustry
7	within ene.	Jumo	Elementary/Secondary (0-12)	College (	1-4or 5+)		oo not use retir k Office		I	Banking	Tndi	ıstrv
7 5	I Hygi other ent, II	Be Co	17. Father's Name (First, Middle, La	st)		Dan	K OIIICE		me (First, Middle, i			
9	Menta Menta <b>arked</b>	To B	Angelo Master					Nettie A				
9	z sno n and ris ma raum		19a. Informant's Name/Relationship				-	et and Number or R on La., Be				Code)
ָב בּ	1 and Healtt Tem 27		Kenneth E. Swab  20a. Method of Disposition	(Son			sition (Name of patory or other pl		Date Date	20c. Location -		wn, State
	rages sent of nt: If it ry or o		1 Burial 2 Cremation 3 4 Doration 5 ☐ Other (Spe		State I	-	natory or other pl s Cemete	i - 4 - 1	0/09	Brookly	n, N	Y
פמונו	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai		21. Signature of Fuveral Service Li	/ /		22 N	Name and Add ew Hyde	ress of Facility Park Fund ville Rd.	eral Home	le Park	NY '	11040
			23a. Part 1. Enter the disease, or co shock, or heart failure. List or	omplications that	caused the deat						, 111	Approximate Interval Between
w F	hysician		Immediate Cause (Final disease or condition	Character of the	922C	wek	lear	Jack	ure		-	Oneet and Death
	/Medical Examiner		resulting in death)	Due to	r as a conseq	uence of):	1100	guel.				
		e.	Sequentially list conditions, if any, leading to immediate	b. Due to	(or as a conseq		usee	To the	LILL.			
	nd ransit	Examiner	Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c				<i>V</i>		_		
00	cate be executed physician and the burial-transit		resulting in death) Last	Due to	(or as a conseq	uence of):						
700	g phys	edical		d							- 8	
<b>X</b>	attending p	an/M	IF FEMALE: 23b. Was decedent pregnant		itcome of pregna		∃Ectopic pregna	ncy			ate of delive	ery Day Year
5	y the at ched fo	Physician/Me	in the past 12 menths? 1 □ Yes 2 □ No 9 □ Unknown	4 □ Preç 9 □ Unk	gnant at time of on nown	death 5	Other (specify)					Day 10th
,	gned b	by Pr	Part II. Other significant condition	s contributing to c	death but not res	1 1 -	nderlying cause (	jiven in Part I.				ne cause of death?
cords,	requir been si hould I	ted	- Mirmeans	alte	Chis	ales	m.	/ . //.		es 2 No		oably 4 ☐ Unknown
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9	ertifica ctor, p	Be C	25. Was case referred to medical examiner?					26. Place of De	1 □ Yes eath <i>(Check only o</i>		1 1 103	Z LINO
> .	this ce		1 ☐ Yes 2 ☐ No		Inpatient 2		it 3 LI DUA		Home 5 Resid			fy)
	After funer	tion	27. Man ■ of Death  1 Natural 5 Pending 2 Accident investiga		nth, Day, Year)	28b. Time of Injury	W	ork? □Yes 2□No	28d. Describe h	low injury occur	ireu	
<u> </u>	r Atten er deat rector: by the	Certification: To	3 Suicide 6 Could no	t be 28e. Plac	e of Injury - At he	I ome, farm, str fy)	eet, factory, office	Э	28f. Location (S City or Tow	Street and Num vn, State)	ber or Rura	al Route Number,
5	urs aft urs aft eral Di		200 Contifice 4 M Contifuing	Dhysisian, To th	a bact of my kee	awladaa daat	h courred at the	time, date and place	no and due to the	cause(s) and m	nanner as s	stated
	e nost 24 ho e Fune letely f	edical	(Check only 2 Medical E.	xaminer: On the and ma	basis of examina nner stated.	ation and/or in	vestigation, in m	y opinion, death occ	curred at the time,	date and place,	, and due to	o the cause(s)
i	vithir To the comp.	Me	29b. Signature and title of certifier			,	29c. Lice	nse number		29d. Date signe	ed (Month,	Day, Year)
	,		14 Rahee	Ther.	silile	anu	111 0	4115		terly	4,0	1009
(	0		29b. Signature and title of certifier  PARAGE  30. Name and address of person w  ACBART  31. Date filed (Month, Day, Year)	no completed cau	ise of death (Iter	m 23a) (Type,	Print)	6A178	HEKSBU	14G, N	11/20	11847
	Sta Registr	ite ar	31. Date filed (Month, Day, Year)	nna Z	Registrar's Signa	ature do	wed					/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Stephanie Sanzone Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 3. Time of Deal 1. Decedent's Name (First, Middle,Last) Physician/ Month Day July 8, 2009 0536 hrs **Medical Examiner** Stephanie A. Sanzone 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Rosedale Franklin Square Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Months Days Hours Min. March 15,1979 Country Maryland Director 1\_\_\_M \_2X\_F 30 220-02-7816 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Yes 2 X No s 23a or 28a-f show notified at once. BelAir Harford Md. hours after death with the Maryland Director 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number USA 902 "H" Jessica Lane 21014 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc Armed Forces? 1 X Never Married 2 Married 2 X No 1 Yes Yes 2X No specify: Specify: White Yes, Give Year Widowed Divorced \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 Pent of Health and Mental Pygiene.

nt: If item 27 is marked other than ""
r other traumatic event, the Medical E Baltimore, MD 21215-0036 Education Teacher 4 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Linda Scranton Be Joseph A. Sanzone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Parkville, Md. 21234 Joseph A. Sanzone 10108 Fontaine Dr. Father 20c. Location - City or Town, State 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 7-13-2009 Baltimore City, Md. Bayview 4 Donation 5 Other Specify: 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral Service Licensee Nottingham, Md. 21236 9705 Belair Rd. Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. Death /Medical a. Pulmonary Thromboembolism Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examine Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and be detached for use as the burial - transit Physician/Medical AMENDED UNPENDED Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month Day Year 3 Ectopic pregnancy Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 No 3 Probably 4 ✔ Unknown Completed

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Be

Yes 2	No 9 ✔ 1	Jnknown	9 Unknown			
art II. Other sig	nificant con	ditions c	ontributing to deal	h but not result	ting in the underl	ying cause given in Part I.

8	24a. Was an autopsy performed? 1 ✓ Yes 2 No	24b. Were autopsy prior to compl death? 1  Yes	findings available etion of cause of
nly	one)		
ιН	ome 5 Residence	ce 6 Other:	
280	d. Describe how injury	occurred	

1 <b>✓</b> Yes 2 No		
27. Manner of Death	28a. Date of Injury 28b. Time of Injury 28c. Injury	at Work? 28d. Describe how injury occurred
1 Natural 5 Pending	(Month, Day,Year)	s 2 No
2 Accident Investig	28e. Place of Injury - At home, farm, street, factory, office buil	ilding, etc. 28f. Location (Street and Number or Rural Route Number, City
3 Suicide 6 Could n	t be	or Town, State)
4 Homicide determi	ed (Specify)	
00- 0-46-4		to the second state of the second of the manner as stated

26 Place of Death (Check of

0	1 ✓ Yes 2 No	inpatient 2 V EN	Outpatient 3 DOA	Training from a	
ion: T	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year)		y at Work? 28d. Descrit res 2 No	e how injury occurred
ertificat	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, (Specify)	e, farm, street, factory, office b	uilding, etc. 28f. Location or Town	n (Street and Number or Rural Rout ı, State)
dical C	one) 2 Medical Examiner: Or	: To the best of my knowledge, on the basis of examination and/ond manner stated.	death occurred at the time, da	ate and place, and due to the ca , death occurred at the time, da	ate and place, and due to the cause
¥.	29b. Signature and title of certifier		29c. License	e number	29d. Date signed (Month, Day

one) 2 Medical Examiner: On the basis of examination and/or and manner stated	investigation, i	in my opinion, death occ	curred at the time, date	and place, and due to the educate)
29b. Signature and title of certifier		29c. License number		29d. Date signed (Month, Day, Year
10 . 11		OCME	OCME	July 8 2009

111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner

. Registrar's Signature 31. Date filed (Month, Day, Year)

Theodore M. King, Jr., MD.

25. Was case referred to medical

**ÓRIGINAL** 

State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 11.35PM **Physician** UCY DOROTHY W. SEXTON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BURNIE ANNE BN ACTIMORE WASHINGTON MEDILAR If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Hours 1 □ M 2 🗷 F Days 96 Maryland Director <u> 212-40-</u>1624 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b County 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evanther must be retified at once. 1 ☐ Yes 2 No Director Severna Park MD Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21146 604 McKinsey Park Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 KNo Specify. If Yes, Give Year or Dates: δ 3 ₩ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Jane Frances Elementary/Secondary (0-12) College (1-4or 5+) School School Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Mabel Shenton ၉ Edward Hube 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 Giddings Avenue, Severna Park, MD 21146 Dorothy R. Blomquist/ 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 MBurial 2 ☐ Cremation 3 ☐ Removal from State Haven Mem Pk 07/08/09 | Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Glen 22. Name and Address of Facility G.J. Gonce Funeral Home, PA 21. Signature of Fraeral Service Licensee Riviera Drive, Pasadena, MD 21122 23a. Part 1. Enterime disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ZHEMEZ /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 

Ectopic pregnancy Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy death? certificate 1 ☐Yes 2 ☐ No 1 □Yes 2 ☑No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After t 5 Pending investigation To the riospinal within 24 hours after death.

To the Funeral Director: Af 1 ☐ Yes 2 □ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and the of certifier

Registrar
DHMH 17 Rev 1/2001

State

me and address of person who co

31. Date filed (Month, Day,

ocause of death (Item 23a) (Type, Print)

301

Division of Vital Records, P.O. Box 68760,

			For State Registrar		epartment of Health and M Certificate of Death		ene2009	22054
			Decedent's Name (First, Middle, Last,	)		2. Date of Death		3. Time of Death
	Physici /Medic		Carl J. Seiland			Month	Day Year 2009	1230pm
1	Examir		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death		4c. County of Deat	h
			Seasons Hospice		Randallstown		Baltimore	
	Funeral Director		212 20 0501	7. Age (In yrs. last birtho 80 Yr	Months   Days   Hours   Min	8. Date of Birth (Month, Day, Jan. 28, 1	Year) 9. Birt Co Det:	hplace (State or Foreign untry) FOLT, MI.
	and		Usual Residence of Decedent  10a, State 10b, County	10c. City, Town o	or Location			10d. Inside City Limits
	Maryl f sho	ō	Maryland Baltimore	: County Luther	ville-Timonium			1 □Yes 2X No
	r 28a	Director	10e. Street and Number	4	10f. Zip Code	10	g. Citizen of What Co	untry?
	h with	a D	108 Castletown Roa	d 101	21093		United Sta	ates
21215-0036	be filed within 72 hours after death with the Maryland that Hyglene. Id other than "natural", or items 23a or 28a-f show event, the Medical Examirer must be rodified at	by Funeral	11. Marital Status  1 ☐ Never Married    3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Aymed Forces? P≦Yes 2 □ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: W	
5-0	72 hc 'natu	etec	15. Decedent's Edu (Specify only highest grad	cation 16a. D	ecedent's Usual Occupation Give kind of work done during most of work ife. DO NOT use retired)	ing 1	6b. Kind of Business/	Industry
121	han "	Completed	Elementary/Secondary (0-12)	College (1-40f 5+)		-	insurance (	
2	e filed within al Hygiene. I other than " vent, the Me		17. Father's Name (First, Middle, Last)	02	Fingineer 18 Mother's Nam	e (First, Middle, Ma	of North Al	merica
and	buld be f Mental I arked of atic eve	Be	Oscar L. Seiland		Helen R.	•	aiden Garname)	
Z	should be and Menta s marked umatic ev	은	19a. Informant's Name/Relationship (Ty	me Print) 19h M	Mailing Address (Street and Number or Rui		City or Town State 2	7in Code)
Maryland	and 2 sealth ar		Marjorie L. Seilan		8 Castletown Road 1		•	n, MD. 21093
Baltimore,	of it		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)	removal nom state	isposition (Name of crematory or other place) uneral Chapel 200	08,	Oc. Location - City or	Town, State
Balt	permit, Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens	F. gan, R.	Peace and Address of Eaching ti 2325 York Road	ves Funer Timonium,	ral&Cremat Maryland	ion Ctr.,P.7 21093
	icate be executed  /Medical Examiner sthe burial-transit	al Examiner	23a. P.nt. Enter the dise of or complished, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. A Company of the C	t enter the mode of dying, such as cardiac cation of Chranica SCASE	or respiratory arres	st,	Approximate Interval Between Onset and Death
587	ficate p phys s the	edical		1				
. Box	the death certific y the attending p ched for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of del Month	ivery Day Year
S, P.	The law requires that the de ate has been signed by the a page 2 should be detached t	þ	Part II. Other significant conditions con	ntributing to death but not resulting in the	ne underlying cause given in Part I.		acco use contribute to	
0.0	w require been signal	Completed				T □ Yes		obably 4 🗷 Unknown
3ec	e law has t	du				24a. Was an autopsy	prior to o	topsy findings available completion of cause of
<u>a</u>						perform 1 □Yes 2		2 □No
Zit.	siciar certif recto	Be	25. Was case referred to medical examiner?	Hospital:		h (Check only one,		DAS HOSPICE
ot	<b>ding Physician:</b> The In. After this certificate hi funeral director, page	은 -	1 ☐ Yes 2 No '	1 ☐ Inpatient 2 ☐ ER/Outp	attent 3 DOA 4 I Nuishig Ho	ome 5 Residen	nce 6 Other (Spe	offys (100) CE
on	ding th. Afte fune	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Inju		Zou. Describe nov	injury occurred	
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director; After this certific completely filled in by the funeral director,	Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)		28f. Location (Stre City or Town,	eet and Number or Ru State)	ıral Route Number,
	e Hospita 24 hours e Funeral letely fille	Medical C	29a. Certifier 1 Certifying Physical Certifying Physical Examione)	Islcian: To the best of my knowledge, oner: On the basis of examination and/and manner stated.	leath occurred at the time, date and place or investigation, in my opinion, death occur	, and due to the ca rred at the time, da	use(s) and manner as te and place, and due	s stated. to the cause(s)
	To th Withir To th comp	Me	29b. Signature and title of certifier	Buiter	29c. License number	29	d. Date signed (Month	n, Day, Year)
	8+1		30. Name and address of person who co	mpleted cause of death (Item 23a) (Ty	5 Smith Avenue	Suite 2	00 Baltu	noro MD
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature	hand of			
DHM	/IH 17 Rev 1/2	001	V Z	wo person p.	7			

**Physician** /Medical **Examiner** 

1. Decedent's Name (First, Middle, Last)

Martin LeRoy Seegmuller

2. Date of Death July 2,

3. Time of Death 2009 7:46 P M

4a. Facility Name (If not institution, give street and number) 11009 Maiden Drive

4b. City, Town, or Location of Death Bowie

4c. County of Death Prince George's

**Funeral** Director

Director

Funeral

2

Be Completed

ပ္

Examine

Be

Certification: To

Medical

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any Injury or other trau

**Physician** 

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records,

P.O. Box 68760,%

/Medical **Examiner** 

attending physician and for use as the burial-trar

Baltimore, Maryland 21215-0036

Usual Residence of Decedent 10a. State MD

1 √ M 2 □ F 59 Yrs 10c. City, Town or Location

7. Age (In yrs. last birthday)

If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) OCT. 31, 1949 Months Days Hours Min.

9. Birthplace (State or Foreign Maryland

10b. County

5. Social Security Numbe 213-54-1993

Prince George's

Bowie 10f. Zip Code 10d. Inside City Limits 1 ☐ Yes 2 No

10e. Street and Number 11009 Maiden Drive

11. Marital Status

1X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 \( \text{Yes} \) 2\( \text{No} \) No If Yes, Give Year or Dates:

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 XNo Specify:

20720

14. Race - American Indian, Black, White, etc. White

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry

10g. Citizen of What Country? United States

12

Elementary/Secondary (0-12) 17, Father's Name (First, Middle, Last)

X-Ray Technician 18. Mother's Name (First, Middle, Maiden Surname)

Healthcare

William A. Seegmuller, Sr.

Mildred Sadler

19a. Informant's Name/Relationship (Type. Print) William A. Seegmuller, Jr. Bro. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4 Anderson Lane, Newark, DE 19711

20a. Method of Disposition Burial 2X Cremation 3 Removal from State

20b. Place of Disposition (Name of cemetery, crematory or other place) Atlantic Crematory

Date 7-7-2009 20c. Location - City or Town, State Glen Burnie, MD

4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

22. Name and Address of Facility Ambrose Funeral Home, Spring Rd., Arbutus, MD 21 Sulphur Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a	<u>Hypertensive</u>	Heart	Disease
	Due to (or as a consequence		
b			
	Due to (or as a consequence	of):	

Due to (or as a consequence of)

3 Ectopic pregnancy

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? ☐Yes 2 ☐ No 9 Unknown

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown

5 ☐ Other (specify)

Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by

Diabetes Mellitus Hypercholesterolema

Tobacco use disorder

24a. Was an autopsy performed? Yes 24 No 1 ☐ Yes

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ♣ No

Year

25. Was case referred to medical examiner? 1X Yes 2 □ No

27. Manner of Death 1 Natural 2 Accident 5 ☐ Pending investigation

determined

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 6 ☐ Could not be

Other: 4 \sum Nursing Home 28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Residence 6 Other (Specify)

29a. Certifier (Check only one)

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

D45217

29d. Date signed (Month, Day, Year) July 6, 2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

to completed cause of death (Item 23a) (Type, Print) 30. Name and address of person

6201 Greenbelt Rd., Suite M18, College Park, MD 20740 Dr. Ajayi, M.D.

State Registrar

32. Registra s Sigr

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ours after death. neral Director: Af filled in by the fur

within 24 hours a

To the Funeral C

completely filled

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 22056

Eric Adam Sellman		For State	St	ate of	Maryla		epartme <i>Certifica</i>		Health an Death	d Ment	al Hyg		eg. No.	20	09 22	05
Physician/		egistrar . Decedent's Name	e (First, Middl	le,Last)								Date of Dea	th		3. Time of Death	
Me-" al Examine	r	Eric Ad	lam Se	ellm	an							Month July 3, 20	Day 09	Year	1331 hrs	
	4	a. Facility Name (i 6825 Real F			reet and nu	mber)		4	b. City, Town, o Woodlawn	Location o	f Death	·		:. County of Death Baltimore Cou		
Funeral	5	Social Security N		6. Sex		7. Age (In	yrs. last birt	hday)	If Under 1 Yea	ar If Unde	r 24Hrs. 8	8. Date of Bir	th(MM	/DD/YYYY) 9. Bir	thplace (State or	
Director	1	215-74-		1 <b>X</b> M	2F		45	Yrs.	Months Day	/s Hours	Min.	Apr.	11	, 1964 <sup>Co</sup>	ountry) MD	
,	_	Jsual Residence of 0a. State	Decedent 10b. County			1100	. City, Town	or Locatio	20	-					10d. Inside City Lin	nits
ow any	ı	MD		ltim	ore	100		odl							1 Yes 2 X	
ryland ryland tong	:  -	Oe, Street and Nu		CIM	010		***	7041	10f. Zip Code			11	0g. Cit	izen of What Cou		$\dashv$
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland been of Health and Mental Hygiene.  If iften 27 is marked other than "natural", or items 23a or 28a-f show in other transmatic event, the Medical Examiner must be notified at once.  To Be Commileted by Funeral Director		6825 Re		cinc	ess	Lane			21207				Ţ	JSA		
or items 23	1	11. Marital Status  Never Marrie	ed 2 M	1: farried	2. Was Dec Armed F		r in U.S.		Decedent of H es, specify Cuba				)-	14. Race - Amei White, etc.	rican Indian, Black,	
er death wi	•	3 Widowed		1	Yes Yes	2	No	1	Yes 2X N	n specify:				Specify: Bl	ack	- 1
2 hours after "natural".  Examiner	ԴԻ	15. Decedent's Ed		10	Dates:		ed) 16a.	Decedent	's Usual Occup	ation (Give I			16b.	Kind of Business	/Industry	$\dashv$
5-0036 ed within 72 hour lygiene. other than "nation the Medical Example Commoleted		Elementary/Seco			College (			during mo	ost of working lif	e. DO NOT	use retired	1)				- 1
5-0036 lled within 72 Hygiene. I other than the Medical		12th gr						Cab	Driver						Industry	7
Hed v		17. Father's Name								18.Mother	's Name (F	irst, Middle,	Maider	n Surname)	_	
2121; Mental Fill marked ic event, J	<u> </u>	Norman  19a. Informant's Na			Print )		119	b Mailing	Address (Stre	LOV	ee A	<u>llen</u>	mber. (	City or Town, Stat	e. Zin Code)	_
nore, MD 21215-0036 sges I and 2 should be filed within 72 hours after nt of Health and Mental Hygiers it. If item 27 is marked other than "natural", other traumatic event, the Medical Examiner To Be Commisted by		Erica S				hter								nore,Ma		234
e, N I and S Health item S		20a. Method of Dis	position				20b. Place	of Dispos	ition (Name of c			Date		. Location - City o		
ages ant of other	- 1	1 X Burial 2			Removal f			•	nerplace) orial	Dark	7/7	/09	TV C	ndlawn	Maryland	,
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene. Important: Iffeen 27 is marked other I injury or other traumatic event, the Med To Be Comm		4 Donation 5 21. Signature of Fu			9		KING		lame and Addre						neral Ho	
<b>A</b> F & <b>A</b>	ł	Der	Dy /	far	1			52	40 Rei	ster					MA21215	
Physician	1	23a. Parti. L., er the	ne disease, only one cause	e on each	line.									nock, or heart	Between Unset	and
∛ Medical ∡aminer		Immediate Cause or condition resulti			larco e to (or as			n) ar	nd cocai	ne in	toxi	cation			Death	$\dashv$
		Sequentially list co		b				_								
in		if any, leading to in cause. Enter Und	erlying Cause		e to (or as	a consequ	ence of):									
ecuted and transit	LYa	(Disease or injury events resulting in		Du	e to (or as	a consequ	ence of):					· ·				
ision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed refeart.  The law requires that the death certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial - transition To Bo Completed by the Description To Bo Completed by the Description To Bo Completed by Description To Bo Completed by Description To Bo Completed by Description To Bo Completed by Description To Bo Completed by Description To Bo Completed by Description To Bo Completed by Description To Bo Completed by To Bo Completed by Description To Bo Completed by Description To Bo Completed by Description To Bo Completed by Description To Bo Completed by Description To Bo Completed by Description To Bo Completed by Description To Bo Completed by Description To Bo Completed by Description To Bo Completed by Description To Bo Completed by Description To Bo Completed by Description To Bo Completed by Description To Bo Completed by Description To Bo Completed by Description To Bo Completed by Description To Bo Completed by Description To Bo Completed Bo Completed by Description To Bo Completed by Description To Bo Completed by Description To Bo Completed by Description To Bo Completed by Description To Bo Completed by Description To Bo Completed by Description To Bo Completed by Description To Bo Completed by Description To Bo Completed by Description To Bo Completed by Description To Bo Completed by Description To Bo Completed By Description To Bo Completed by Description To Bo Completed By Description To Bo Completed By Description To Bo Completed By Description To Bo Completed By Description To By Description To By Description To By Description To By Description To By Description To By Description To By Description To By Description To By Description To By Description To By Description To By Description To By Description To By Description To By Description To By Description To By Description To By Description To By Descript	5	XUNPENDED	)		AMENDED	23a,	27,28	a-f , j	perME, §	3894 8	3/13/0	09 TT				
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BO) e death the att	֡֝֝֝֟֝֓֓֓֟֝֟֝֟֝֓֓֓֓֟֝֟֓֓֓֓֓֓֟	1 Yes 2	No 9 Ur	nknown	9 Unkr	nown			(4)							
of Vital Records, P.O. Box 6876 ling Physician: The law requires that the death certificate.  After this certificate has been signed by the attending phy funeral director, page 2 should be detached for use as the law to Do Commisted by the Directician M.	١-	Part II. Other sign	ificant cond	itions c	ontributing	to death bu	t not resulting	ng in the	underlying caus	e given in P	art I.			politica .	to the cause of death	- 1
S, F quires en sign					_			-				24a. Wa			autopsy findings avai	
Records, The law require: ate has been sig												aut	opsy formed	prior to	completion of cause	e of
Rec The liftcate   page	∟						_					1 🗸 Yes			Yes 2 N	0
ician: ician: rector	2	25. Was case refe examiner?	rred to medic		spital:	Inpatient	2 ED//	Dutpatien		Other		Home 5	Resi	dence 6 ✔ Oth	ner: Scene	
of V Physical dispersion of the control of the cont	<u>:</u>	1 ✓ Yes 27. Manner of Dea	2 No		28a. Dat	e of Injury	28b	. Time of		njury at Wor				njury occurred		
ion c tending eath. lor: Af the fun		1 Natural		nding	(Mon	th, Day Year		20 pi	m FD 1□	Yes 2	K No	unk				
Division tal or Attendi rs after death. al Director: A led in by the fu	IICati	2 Accident 3 Suicide	6 X Co	estigation	7.0		y - At home,	farm, stre	et, factory, offic	e building, e	etc. 2	28f. Location	(Stree	t and Number or	Rural Route Number	City
Divi spital or spital or or or after after in filled in filled in	า ⊢	4 Homicide	det	termined	(Specify		house								Rural Route Number, al Princes	
8	<u>.</u>	29a. Certifier (Check only one) 2	Certifying I	aminer:	n the basis	of examin	nowledge, di ation and/or	eath occu investiga	rred at the time, ation, in my opin	date and p ion, death o	lace, and o	due to the ca the time, da	use(s) te and	and manner as st place, and due to	ated. the cause(s)	
\$ 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Me	29b. Signature and	d title of certif		nd manner	stateu.			29c. Lice	nse numbe	r		29	d. Date signed (A	fonth, Day, Year)	
		Walls	nto A	no C	Coull				0.0	C.M.E.			Ju	uly 4, 2009		
otpurk	-	30. Name and add			mpleted ca				enn Street,	Baltimor	e, MD 2	1201				
Stat	e	31. Date filed (Moi				Registrar's				<del></del>						
Registra	ar	- 3	UL 10	2009	12	men -	1	pa						OCME		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 07/02/09 **Physician** Carl Smith 6:19 /Medical р 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** na Baltimore 1602 Wadsworth Way 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Months Days Hours Director MD 03/24/1940 218**-**36**-**5301 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examinar must be required at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1X Yes 2 □ No Baltimore na 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21239 USA 1602 Wadsworth Way 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: Ś Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) factory Machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Chambers Theodore Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Samarian Smith/wife 1602 Wadsworth Way Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/13/09 Owings Mills, MD Garrison Forest Vet. 22. Name and Address of Facility 21. Signature of Euneral Service License 4300 Wabash Avenue Management All West Baltimore, MD 20a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. recomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** o mantins sair como /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE. 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has be rector, page 2 sl 24a. Was an autopsy 2 **X** No 1 ☐ Yes 2 ☐ No 1 ☐ Yes s fiter death.

I Director: After this certificate in by the funeral director, p. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours filler 29a. Certifier 15 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 ho

To the Fune

completely f (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signatule and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOS-7936 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UD 22 s. Creene St. Baltimore, MD 21201. Heather D. Mannuel 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 1 0 2009 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

		Please	Type or Print State of Mai								00050
		State Registrar			Cer	tificate of	Death		Reg. No.	003	22058
Dhysisi		1. Decedent's Name (First, Middle, L	ast)					Date of Dea     Month	ath Day	Year	3. Time of Death
Physici: /Medic		LAWRENCE	R		S	EIDMAN		JULY	7	2009	11:05 P <sup>M</sup>
Examin	er	4a. Facility Name (If not institution, g					r Location of Deatl	n	4c. Co	unty of Death	20.5
		GILCHRIST HOSP 3 5. Social Security Number 6.		(In vre la	st birthday)	TOWS	SON Tilf Under 24 Hrs.	8. Date of Birt	th	BALTIMO 9. Birtho	JKE lace (State or Foreign
Funeral Director		217-62-1255	1 X M 2 □ F	45	Yrs.	Months Days	Hours Min.	(Month, Da	y, Year)	Coun	MD
		Usual Residence of Decedent		45				104/0//_	1304		
rylan show	_	10a. State 10b. County		10c. City,	Town or Loc	cation				1	0d. Inside City Limits 1 ☐ Yes 2 <b>X</b> No
8a-f s	Director	MD BALTI	MORE			OWINGS 1	MILLS		10 0'''		
vith th	Ë	10e. Street and Number				10f. Zip Code			10g. Citizer	of What Coun	nry?
eath v	eral	6 CAROLYN COURT	12. Was Decedent Ev	er in U.S.	13 \	Vas Decedent of I	17 Hispanic Origin? (S	specify Yes or No	- 14.	Race - Americ	an Indian,
fter d	Funeral	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☑ Married</li></ul>	Armed Forces? 1 ☐ Yes 2 ☑ No		I	f Yes, specify Cub	an, Mexican, Puer	o Rican, etc.)		Black, White, 6	etc.
ar", o	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give ^ Year or Dates:		1	I∐Yes 2 <b>X</b> ∏No	Specify:		Sp	pecify: WH	ITE
72 hc	etec	15. Decedent's l (Specify only highest g	Education rade completed)		(Give	dent's Usual Occu kind of work done	during most of wor	rking	16b. Kind	of Business/Inc	dustry
vithin	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	)		OO NOT use retire ATTORNEY	)d)			LAW	
filed v Hygie ther i	မ လ	17. Father's Name (First, Middle, Las				HITOKNET	18. Mother's Nar	me (First, Middle,	Maiden Su		
id be ental ked o ic eve	To B	HERBERT		DMAN			МД	RLYN		ROBINS	SON
shouland Mand Mand Mandal	-	19a. Informant's Name/Relationship		Dilli	19b. Mailir	ng Address (Stree	t and Number or Ri		er, City or To		
1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natura", or items 23a or 28a-f show wither traumatic event, the Medical Examinar must be incomed at		JILL SEIDMAN / V	VIFE		6 C	AROLYN C	OURT, OWI	NGS MILI	S, ME	2111	7
es 1 a		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	Removal from State	20b. Pla	ice of Dispo metery, cren	sition (Name of natory or other pla	ce)	Date	20c. Local	tion - City or To	own, State
Pag tment tant:		4 □ Donation 5 □ Other (Spec		H.	AR ŞIN			9/2009			MILLS, MD
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination in any injury or other traumatic event, the Medical Examination in any once.		21. Signature of Funeral Service Lic	ensee				ess of Facility SC			•	
445		23a. Part 1. Enter the disease, or co	molications that caused t	he death			TERSTOWN			LE, MU	21208 Approximate
		shock, or heart failure. List on	y one cause on each line	i.		,		o or roopa.o., a	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Interval Between Onset and Death
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death certificate be attending physicia I for use as the bur	dic		d								
nding use a	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o			7			230	d. Date of deliv	ery
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/sicla s cert directo	0	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatier		R/Outpatier	nt 3 DOA Ot	hor:	ath <i>(Ch</i> eck o <i>nly c</i> Home 5 ☐ Resi		Other (Speci	w Hospice
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pital c		29a, Certifier 1 Certifying	Physician: To the best o	f my knou	lodge deat	h occurred at the	time, date and place	o and due to the	called(s) a	nd manner as	stated
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the but	Medical	(Check only 2 Medical Ex	and the state of		1/ !		ambabas dankhi ana	command and Alexandrian	alaka aaala	lana and due t	a the course(s)
To the	Me	29b. Signature and title of certifier	1-0			29c. Licer	ise number		29d. Date	signed (Month,	Day, Year)
		14/1 Anth	y Klila	7: 0	4)	1)2	5205		July	, 8, 6	2009
12		30. Name and address of person wh	o completed cause of de	ath (Item	23a) (Type,	Print) (Pre	ules ST	+. Bali	Po. 1	nd Z	2070
Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signati	1 1	arkel	ise number  \$20.5				
Registr	ar	JUL 10	2009 /		- 14						

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 6, 2009 **Physician** 6:45 рм Jean Ann Sweeney /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Oak Crest Care Center Parkville 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Feb 19ay, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Months Il i i i i i i s 215-28-2659 80 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, the Modical Examinar must be notified at Baltimore Parkville MD 1 ☐ Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8810 Walther Blvd., #1121 21234 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ∐Yes 2 LXNo Specify: White ğ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within hand Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Education Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be von Briesen Ruth E. Brissenden John Wagner ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once. 8810 Walther Blvd., #1121 Parkville, MD Stanley Stockwell-husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 7/8/09 Hilltop Serv Corp Towson, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. MM 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive /Medical Due to (or a consequence of): **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): been signed by the aftending physician hould be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) ☐Yes 2MNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ★ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Renal completely filled in by the funeral director, p  $\langle$  ge 2  $_{8}$ autopsy perform 1 ☐Yes 2 ☐No 1 ☐Yes 2 No Morbid 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ Phospital or Attending Ph 24 hours after death. Funeral Director: After th 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RO67343 WALTHER BING. PARKVIlle, M. 21234 BRAZIER

State Registrar

DHMH 17 Rev 1/2001

Itimore, Maryland 21215-0036

P.O. Box 68760

Records,

of Vital

Division

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31. Date filed (Month, Day, Year)

# Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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pu »	-	Usual Residence of Decedent  10a, State 10b. County		10c. City.	Town or Lo	cation						10d. Inside City Limits	$\dashv$
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r 28a	irec	10e. Street and Number				10f. Zip	Code			10g. Citize	en of What Cou	ntry?	
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er des items	Funeral Director	11. Marital Status 12  1 ★ Never Married 2 ☐ Married	Mas Decedent 8 Armed Forces? 1   Yes 2x  N		13.	Was Dece If Yes, spe	dent of His cify Cubar	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or N Rican, etc.)	0- 14	<ol> <li>Race - Amer Black, White,</li> </ol>		
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2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Modral Experient rest be notified at		19a. Informant's Name/Relationship (Type				-		and Number or Ru				p Code)	
1 and Health Sm 27 ther to	-	Regina Baltimore/ S  20a. Method of Disposition	Sister	20h Pla				K Court,	Severn	T	21144 ation - City or T	own. State	$\dashv$
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)		Raymon Miller	ms				D4-	7683		July	8,20	29	
11		30. Name and address of person who com	npleted cause of o	death (Item :	23a) (Type,	Print)		7683 Rustretus	. 100	7117 1			
Stat	е	31. Date filed (Month, Day, Year)	32. Registr	rar's Simatu	TO CAL	and of	2 /	WINTOW	1	01136			_
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 06, 1:00 AM Thomas Joseph Toolan July 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Worcester Snow Hill Nursing Home Snow Hill 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1**∑**M 2□ F Director 217-18-5948 85 08/22/1923 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov 1 ☐ Yes 2√2 No Director Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1723 Wycliffe Avenue 21234 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Completed by Specify White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Martin's Air Craft other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Thomas Toolan Elizabeth Bessie Fenie ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 00 of Health a item 27 is Pamela Nixon/ Daughter 416 W. Market Street, Snow Hill, MD 21863 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cametery 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If it any Injury or c 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07/10/09 Parkville, MD 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services 21. Signafure of Fungral Service Licensee 8800 Harford Rd. Parkville, MD 21234 23a. Part. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ship ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Duna **Physician** disease or condition /Medical resulting in death) Due to (or as a consequent e of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran Due to (or as a consequence of) P.O. Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No director, page 2 should be detached 9 DlJnknowr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy 2 **1** No 1 □Yes 2 □No 1 TYes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 vursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) After 1 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 □Yes 2 □No thours after death. 2 Accident investigation 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier i 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)-

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Box 68760, P.O. I or Vital Records, Division

Maryland 21215-0036

Baltimore,

within 24 hours after death.

To the Funeral Director: /
completely filled in by the fi the Hospital ical State Registrar

MONIGUE 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

EANESTON 1414

29a. Certifier

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1447494

LOREST

29d. Date signed (Month, Day, Year)

PR. ANNAPOLIS,

### State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** PHYLLIS 07 TAPPER 07 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RANDALUSTOWN MD PUTURE CAREOLD COURT If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Months 215-12-3073 1 ☐ M 21X F Hours 9 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I flem 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar miss to account and Injury or other traumatic event, the Medical Examinar miss to account and injury or other traumatic event, the Medical Examinar miss to account and injury or other traumatic event, the Medical Examinar miss to account and injury or other traumatic event, the Medical Examinar miss to account and injury or other traumatic event, the Medical Examinar miss to account and injury or other traumatic events. 10c. City, Town or Location 1∩a State 10h County TIMOre Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Oth 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ouise 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Sincremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 13a Cremeton 0 21. Signatur of Funeral Service Ligensee 22. Name and Address art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final theo. e bilue. Physician romental disease or condition resulting in death) /Medical Due to (or as a consequence of) Examine 01.0 Sequentially list conditions, if any teaching to in interaction cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner the death certificate be executed Atriol attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 M Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Month

Day

08,2009

Year

2009

BACTO

9. Birthplace Country)

Black, White, etc.

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ac

(State or Foreign

10d. Inside City Limits

Interval Between Onset and Death

1 Yes 2 No

ned by the a signed by or Vital Records, has page 2 certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Division

Be

Certification: To

Medical

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☑ No

27. Manner of Death

1 X Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

ADCHEMISI

31. Date filed (Month, Day, Year)

Hospital:

30. Name and address of person who complet of cause of death (Item 23a) (Type, Print) SOSAN

5 ☐ Pending investigation

6 Could not be

9000

JUL 1 0 2009

determined

1 Inpatient

m. 0

32. Registrar's Signature

28a. Date of Injury (Month, Day Year)

State Registrar

DHMH 17 Rev 1/2001

2600

2 ER/Outpatient 3 DOA

28c. Injury at Work?

29c. License number

1 ☐ Yes 2 ☐ No

00061439

LIBERTY HOGHTS INE, BALTIMORE, MB 21215

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Donald Williams Tucker  $\mathbf{P}^{\mathsf{M}}$ July 7, 2009 12:05 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day You Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Year) 928 Days Months Hours Min. 1**∑** M 2□ F 213-26-7523 80 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 V No Parkville MD Baltimore 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21234 U.S.A. 8810 Walther Blvd, Unit 2403 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 No If Yes, Give 51 - 53 Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: White Specify: 3 Midowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Civil Engineer Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Williams Tucker Elsie Elizabeth Roland George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 304 W. Pennsylvania Ave., Towson, MD 21204 David C. Haile-Attorney 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition Parkwood Cemetery 1 Burial 2 Cremation 3 Removal from State 7/11/09 Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee William G. Dau 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ACUTE RESPIRATORY FAILURE Immediate Cause (Final TWO DAYS disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ARTERY DISCASE LUNG CANCER 1 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐Yes 2 ☐ No 1 ☐ Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred

**Physician** /Medical Examiner

attending physician

signed by

After this

within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral

δ

Completed

Be

Certification: To

cal

the Hospital or Attending Physlcian: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Director

Funeral

2

Completed

Be

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Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Motical Extra ninest be a cutilised at once.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner as the burial-trar that initiated events resulting in death) Last Physician/Medical

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

25. Was case referred to medical examiner? 1 Yes 2€No

27. Manner of Death 1 Natural

5 Pending investigation 2 Accident 6 ☐ Could not be 3 Suicide

28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

28b. Time of 1 ☐Yes 2 ☐No

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

OSLER

29d. Date signed (Month, Day, Year)

TOWSON, MD DIZOY

30. Name and address of gerson who completed cause of death (Item 23a) (Type, Print) MO

31. Date filed (Month, Day, Year)

32. Registrar's Sign

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 12:00P M 2009 June 30 David Wiseman /Medical 4a. Facility Name (If not institution, give street and number Manor 4c. County of Death 4b. City, Town, or Location of Death Examiner Rossville Baltimore If Under 194 Hrs. 6600 Ridge Road Care

i. Social Security Number 6. Sex 7. Baltimore Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 06.30.1939 MD 219.26.8754 70 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State "natural", or items 23a or 28a-f show 1 ☐ Yes 2 No Director Baltimore MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21206 4512 Raspe Ave Funeral Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry marked other than "nature imatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Automotive Salesman 12 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) 2 should be fill and Mental H Frank Andrew Wiseman, Sr. Mildred Elizabeth Pyne P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) .00 Pages 1 and 2 s ment of Health ar Nancy Warren/Niece 19 Leslie Avenue, Baltimore, MD 21236 item 27 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages
Department of
Important: If it
any injury or c 1 ☐ Burial 2 ☐ remation 3 ☐ Removal from State Chesapeake Crem. 07.09.09 | Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CAFA/ Stephen D. Lohrmann, 21. Signature of Funeral Service Licensee MOIYY3 P.A. 8717 Green Pastures Dr. BAlto., 23a. Part1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last iner Due to (or as a consequence of) law requires that the death certificate be executed Exami burial-tra Due to (or as a consequence of): physician Physician/Medical the attending p as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) signed by the a ld be detached f P.0. 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed? certificate 1 ☐ Yes 2 ☑ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28b. Time of Injury 27. Man of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Noverelas
31. Date filed (Month, Day,

Walknam Woods Road. MD 21234

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 07 **Physician** 0300 M 06 AVID /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Linthicum House Tate Hospice Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex **Funeral** Hours Min. Months Days 1 M 2 □ F 86 New York 723-16-3818 3/13/1923 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10a. State 10h County 28a-f show Department of Health and Mental Hygiene. Important; if items 23a or 28a-f show amportant; if item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the "Vedical Expanitive rivest be notified at once. 1 ☐ Yes 2 🔀 No Director Anne Arundel Annapolis MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21401 28 Bunche Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 □ No 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene. 1 ☑Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White ģ 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineer Electrical 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Regina Doherty ပ John Edmond Walsh Anna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 16520 Abbey\_ Kelli Pletsch/ Daughter Drive, Bowie, MD 20715 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry 7/8/2009 Hanover, Maryland 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Ineral Servi Licensee 7522 Connelley Dr., Ste, P, Hanover, MD 21076 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 9 Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 2  $\square$  No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After t 1 Natural 5 Pending investigation in 24 hours a let deam.
The Funeral Director Af 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated within 2.

To the F
complet the 29d. Pate signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number

State Registrar

31. Date filed (Month, Day, Year) JUL 1 0 2009

NIA M 44 DEFENSE HIGHWAY ANNAPOLI) MOU401 32. Registrar's

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

Physician Modical   Scientific   All   A			1	For State of Maryland /   State of Maryland /   Registrar		rtment of H			gierie Reg. No. 2	000	2206
Examiner  Fundal  Fund			1		erki	ng		Month	Day		3. Time of Death 10:10 P.M
Use   Part   P			4								
To Sale and Number   10c. City, Town or Location   10c. City, Town or Location   10c. City	_	5					(Month, Da	ay, Year)	9. Birti Co. Man	hplace (State or Foreign untry) Cyland	
Elementary (Secondary (Or 2)   College (1-4of 5+)   Bookkeeps   Manufacturing   Bookkeeps   Manufacturing   Bookkeeps   Manufacturing   Bookkeeps   Manufacturing   Is. Mother's Name (First, Middle, Last)   Is. Mother's Name (First, Middle, Marking Caumann)   Is. Mother's Name (First, Middle, Last)   Is. Mother's Name (Fi	Maryland f show	jo	1	0a. State 10b. County 10c. City, Tow		cation					10d. Inside City Limits 1 □ Yes 2x No
The part of the	h with the N 23a or 28a-			0e. Street and Number	16		)715		J		untry?
The part of the	36 s after deal			Armed Forces?  1 ☐ Never Married 2 ☐ Married If Yes, Give				ecify Yes or No Rican, etc.)		Black, White	e, etc.
18. Mother's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Surface)   18. Mother's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Last)   18. Mother's Name (First, Middle, Surface)   18. Mother's	215-00 thin 72 hour ie. an "natural	npleted	_	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give I life. D	kind of work done of OO NOT use retired	ation during most of work l)	ing		of Business/	Industry
20. Method of Disposition  20. Method of Disposition  20. Plane of Disposition (Name of Commerce)  20. Control of Commerce (Specify)  21. Signatures (Period Service P.A.  22. Name and Address of Facility  23. Part I. Enter the disease, or complications that causes the death. Do not enter the mode of drying, such as acridiac or respiratory arest, shock, or heart failure. List only one cause on eagh line.  23. Part I. Enter the disease, or complications that causes the death. Do not enter the mode of drying, such as acridiac or respiratory arest, shock, or heart failure. List only one cause on eagh line.  24. Due to (or as a consequence of):  25. Sequentially list conditions, daily are the part 12 promiting at the	and 21 Ibe filed wif ntal Hygien ed other the	Be	1	10th 7. Father's Name (First, Middle, Last)	Boo	kkeeper			, Maiden Sur	rname)	uring
To Burial 2   Cremation 3   Removal from State   Loudon Park Cemetery   07/08/2009   Baltimore, Mary1   Concerning   Con		۲		, , ,		,					
23a. Part I. Einer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval a process shock, or heart failure. List only one cause on each line.  Physician Medical Examiner  25a. Part I. Einer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval a process shock, or heart failure. List only one cause on each line.  Physician Medical Cause (Finer Underlying disease or condition resulting in death)  25a. Part II. Other significant conditions, if any, seeding in grammature cause. Einer Underlying as a consequence of):  Due to (or as a consequence of):  Due to (o			2	11A Burial 21 It remation 31   Bernoval from State						•	
Physician   Medical Examiler   Physician	Balt  Permit. Depart Imports any Inj	i dire		Homo Clariage	4	001 Ritcl	60 <u>nie Highw</u>	ay Bal	timore		yland 21225
Spanning of the part of the pa	/Medica Examine			shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence by the conditions of the conditions)	e of):	By F	PAILU				Interval Between Onset and Death
Spood of the first		edical		that initiated events resulting in death) Last  C. Due to (or as a consequence of the co	ath 3⊑		y		23d		
25. Was case referred to medical examiner?    The property of the property of	P.O. hat the did by the letached			1 ☐ Yes 2 Do 9 ☐ Unknown 9 ☐ Unknown			en in Part I.	23e. Did	tobacco use	contribute t	o the cause of death?
25. Was case referred to medical examiner?    The proof of the proof o	cords, v requires to been signification in the contraction of the cont		2							24b. Were a	utonsv findings available
The state of the s							26. Place of Dea	auto perf 1 □ Yes	opsy formed? 2 100	prior to death?	completion of cause of
29a. Certifier (Check only one)   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.	ing ling Afte une	ျ	2	1 Yes 2 No Hospital: 1 Inpatient 2 PER/C 27. Manner of Ceath 1 No Natural 5 Pending investigation (Month, Day, Year)	. Time of	f 28c. Inju	ry at k?				ecify)
29a. Certifier (Check only one)   Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mariner as stated.   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of examiner stated.   29b. Signature and time of configure   29c. License number   29d. Date signed (Month, Day, Year of the cause of death (Item 23a) (Type, Pript)   10c.   29c. License number   29d. Date signed (Month, Day, Year of the cause of death (Item 23a) (Type, Pript)   10c.   29c. License number   29d. Date signed (Month, Day, Year of the cause of death (Item 23a) (Type, Pript)   10c.   29c. License number   29d. Date signed (Month, Day, Year of the cause of death (Item 23a) (Type, Pript)   10c.   29c. License number   29d. Date signed (Month, Day, Year of the cause of death (Item 23a) (Type, Pript)   10c.   29c. License number   29d. Date signed (Month, Day, Year of the cause of death (Item 23a) (Type, Pript)   10c.   29c. License number   29d. Date signed (Month, Day, Year of the cause of the cause of death (Item 23a) (Type, Pript)   10c.   29c. License number   29d. Date signed (Month, Day, Year of the cause of the ca	Divis ital or Atte us after de ral Directo			4 Homicide determined 256. Flace of injury Actionite, building, etc. (Specify)				City or To	own, State)		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 70	the Hosp thin 24 hou the Fune	Medical	-	(Check only   Medical Examiner: On the basis of examination and manner stated.	and/or in	nvestigation, in my	opinion, death occu	rred at the time	e, date and pl	lace, and du	e to the cause(s)
	A 18 50		1	30. Name and address of person who completed cause of death (Item 23)	a) (Type	D	3 45	5	07-	-06	-2009
State State Registrar  State Registrar		itate		5-J-BAO, ND; 4000-Mt 31. Date filed (Month, Day, Year) 32/Registrar's Signature	che	elline	froat !	# 208	; Dan	F -1	W - 2070

DHMH 17 Rev 1/2001

thy Avera	Weatherly	
5251 0	Please Type or Print in Black Indelible Ink. Ensure All Copies Are State of Maryland / Department of Health and Mental Hygien	e Legible.
. OINK	1- For State Certificate of Death	2009 220
Physician/	Mont	of Death th Day Year 0320 hrs
dical Examine	4. City, Town, or Location of Death	4, 2009 4c. County of Death
	31 Pritchard Avenue Apt. G 2 Aberdeen	Harford
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date Months Days Hours Min.	te of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country)
Director	101-68-9000 12M 2 F 25 Yrs. 3	-31-1984 Mrw Gode
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
<b>È</b>	N.Y Bront Bront	1 X Yes 2 No
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. ant: If iten 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once. To Be Commileted by Funeral Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
ith the 23a or notification 23a or notification 23 or		es or No- 14. Race - American Indian, Black,
er death with , or items 23 r must be no	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	etc.) White, etc.
s after d	or Dates:	Specify: 3 a.c.
hours "natur	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of work dor during most of working life. DO NOT use retired)	ne Tibb. Killa of Business/filaustry
5-0036 ed within 72 hour lygiene. other than "natu	Self Emploxial	Construction
5-00 iled with Hygier I other II other II		Middle, Maiden Surname)
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Flural Re	oute Number, City or Town, State, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Extminer To Re Commissed by I	Sherry Weatherly mother 19 Southern Blad &	Albany, 7.4. 12209
re, rand FHealt Fitem er trau	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)	201: Location - City or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite	4 Donation 5 Other Specify: Wood awn rematery 1-19-	2009 Bronx n.Y.
Balti permit. Departm Imports injury o	Carl training	Euneral 5270, CR. 1.
Physician	23a. Part I. Enter the disease, or complications that capted the death. Do not enter the mode of dying, such as cardiac or resting	ratory arrest, shock, or heart Approximate Interval Between Onset and
'Medical	failure. List only one cause on each line.  Immediate Cause (Final disease a. GunShot Wound (1) of Left Shoulder and Chest	Death
(aminer	or condition resulting in death)  Due to (or as a consequence of):	
	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):	
i i	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	
executed an and al - transit	d.	
be exesician a	UNPENDED AMENDED	
tal Records, P.O. Box 68760, cian: The law requires that the death certificate be executed certificate has been signed by the attending physician and ector, page 2 should be detached for use as the burial - transit	IF FEMALE: 23b. Was decedent pregnant in the 2 Secretary 2 Secretary 2 Secretary 3 Secreta	23d. Date of delivery  Month Day Year
ath cert	past 12 months?  4 Pregnant at time of death 5 Other (Specify)	
by the a sched for schedule for sch	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
P.O. es that the igned by be detach		1 Yes 2 No 3 Probably 4 Unknown
Records,  The law requires ficate has been sig		24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of
eco The law ate has	1	performed? death?  Yes 2 No 1 Yes 2 No
tal R	b 25. Was case referred to medical	
F Vit	1 V yes 2 No 28a Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d.	ne 5 Residence 6 VOther: Scene Describe how injury occurred
O m == 2   '	27. Walling of Deading 1	ect shot
ndin Ith.	T Chaing	
r Attendin ter death. irrector: A in by the fu	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. L	or Town State)
Division of Vital Records, pital or Attending Physician: The law requinours after death. Increase Director: After this certificate has been sifilled in by the funeral director, page 2 should be after the control of the funeral director.	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. L (Specify) Multi-Family Apt. 31 Pr	or Town, State) ritchard Avenue Apt G 2, Aberdeen , Md.
spi hou hou		or Town, State) ritchard Avenue Apt G 2, Aberdeen , Md. o the cause(s) and manner as stated.
spi hou hou	2a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to (Check only)	ritchard Avenue Apt G 2, Aberdeen , Md. o the cause(s) and manner as stated.
spi hou hou		or Town, State) ritchard Avenue Apt G 2, Aberdeen , Md. o the cause(s) and manner as stated. time, date and place, and due to the cause(s)
spi hou hou	Sear Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the transport and manner stated.  29b. Signature and title of certifier  29c. License number  O.C.M.E.	or Town, State) ritchard Avenue Apt G 2, Aberdeen , Md. o the cause(s) and manner as stated. time, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)
spi hou hou	Sear Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time and manner stated.  29b. Signature and title of certifier  O.C.M.E.	or Town, State) ritchard Avenue Apt G 2, Aberdeen , Md. o the cause(s) and manner as stated. time, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 87 2009 12:10 a M 0. Ward Beecher 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Timonium Stella Maris If Under 1 Year | If Under 24 Hrs. 8, Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1 💢 M 2 🗆 F 66 Feb 20, 219-38-9256 1943 Tennessee Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 X Yes 2 □ No Baltimore N/A Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21215 2500 Belvedere Ave. #309 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 👿 Married 1 ☐ Yes 2 X No Specify. Specify: **Black** 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Roofing Roofer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ward Nina unknown Ohara 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 607 Pennsylvania Ave. Baltimore, Md. 21201 Mrs. Mary Ward/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7-9-09 Woodlawn, Md. Lorraine Park Cem. 4□Donation 5 □Other (SpecEntombment 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral/Sprvice / cense 1050 York Rd. Towson, Md. 21204 23a. Part 1. Enter the disease, or comblications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):

physician and s the burial-trans Division of Vital Records, P.O. Box 68760, cate has been signed by the attending p page 2 should be detached for use as within 24 hours after deat To the Funeral Director:

**Physician** 

/Medical

Examiner

Director

Funeral

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Be Completed

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**Funeral** 

**Director** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Exprinted reast be notified at once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

7, 2009

death with the Maryland

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c	I death 3 Ectopic p			23d. Date of delivery Month Day Year	
Part II. Other significant conditions con	ntributing to death but not res	ulting in the underlying c	ause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?  2 □ No 3 ▼ Probably 4 □ Unknown	
		<u></u>		24a. Was an autopsy performed 1 Tyes 2	24b. Were autopsy findings available prior to completion of cause of death? No 1 \( \subseteq Yes \) 2 \( \subseteq No \)	
25. Was case referred to medical			26. Place of De	ath (Check only one)		
examiner? 1 ☐ Yes 2 XNo	lospital: 1 🗌 Inpatient 2 🗆	ER/Outpatient 3 DO	Other: 4 🗆 Nursing I	Home 5 ☐ Residence	6 Other (Specify) OSPICE	
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)		8c. Injury at Work? 1 □Yes 2 □ No		28d. Describe how injury occurred	
3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam)	sician: To the best of my knowner: On the basis of examination and manner stated.	owledge, death occurred ation and/or investigation	at the time, date and place, in my opinion, death occ	e, and due to the caus- urred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)	
29b. Signature and title of certifier	ennp	290	c. License number R/49792	29d.	Date signed (Month, Day, Year) 7   7   2009	
30. Name and Idd ss of Frson who co	ompleted cause of death (Iter	n 23a) (Type, Print)	WEY RD	TIMONIU	M, MD 21093	

DHMH 17 Rev 1/2001

State Registrar

/illiam Ward	State of Maryland / Department - For State Certificate	t of Health and Mental Hygier e <i>of Death</i>	ne 2009 2207			
Physician/	Registrar 1. Decedent's Name (First, Middle,Last)		e of Death 3. Time of Death			
Medical Examiner	William Cephas Ward, Jr.	July	y 9, 2009 O016 hrs			
	4a. Facility Name (if not institution, give street and number) Franklin Square Hospital	4b. City, Town, or Location of Death Rosedale	Baltimore County			
Funeral	Social Security Number 6. Sex 7. Age (In yrs. last birthda)	y) If Under 1 Year If Under 24Hrs. 8. D.	ate of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Country)			
Director	212-22-1242   1XM 2 F   83	Yrs. Months Days Hours Min. Ap	ril 26, 1926 Maryland			
	Usual Residence of Decedent  10a, State 10b, County 10c, City, Town or L	coction	10d. Inside City Limits			
ow any	Md. Baltimore Baltim		1 Yes 2 XNo			
the Maryland a or 28a-f show tified at once.  Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?			
hours after death with the Maryland natural", or items 23a or 28a-f sho Examiner must be notified at once.	4805 Royahn Ave.	21236	USA			
er death with or items 23 must be no Funeral	A-mad Farence	Was Decedent of Hispanic Origin? (Specify No. 1974) If Yes, specify Cuban, Mexican, Puerto Rican,	(es or No- etc.) 14. Race - American Indian, Black, White, etc.			
er death, or ite	1 X Yes 2 No	Yes 2 X No specify:	<sub>Specify:</sub> White			
urs afte tural", mines	15. Decedent's Education (Specify only highest grade completed) 16a. Dec	edent's Usual Occupation (Give kind of work do				
e la 2	Elementary/Secondary (0-12) College (1-4 or 5+)	ng most of working life. DO NOT use retired)	US Postal Service			
5-0036 led within 72 hours a tygiene. other than "natura the Medical Examin Completed by	10	ilman	, Middle, Maiden Surname)			
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	17. Father's Name (First, Middle, Last) William C. Ward, Sr.		lliams			
D 21215-0036 should be filed within and Mental Hygiene. 7 is marked other tha natic event, the Media To Be Compl	19a. Informant's Name/Relationship (Type, Print )	dailing Address (Street and Number or Rural F 805 Royahn Ave Baltim				
M 2 aum		isposition (Name of cemetery, Date				
Baltimore, MD 2 spernit. Pages I and 2 shou Oepartment of Health and Important: If item 27 is ninjury or other traumatte	1 Rurial 2 Cremation 3 Removal from State crematory	or other place) Service Co. 7-14-0	og Towson, Md.			
Baltimore permit. Pages 1 Department of F Important: If injury or other	4 Donation 5 Other Specify:  21. Signature of Fundal Service Licey ee	22. Name and Address of Facility Ruck Towson Fur				
Ba pern Pern Imp	MILA	1050 York Rd. T	owson, Md. 21204			
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not e failure. List only one cause on each line.		Detween once and			
xaminer	Immediate Cause (Final disease or condition resulting in death)  a. Sepsis complicated  Due to (or as a consequence of): Car	by hypertensive athe liovascular disease	roscierotic			
	Sequentially list conditions, b					
iner	if any, leading to immediate Due to (or as a consequence of).  cause. Enter Underlying Cause					
ted Insit Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit perfical Certification: To Be Completed by Physician/Medical Exi	X UNPENDED XAMENDED #1 as noted	, 23a,PII,2/,per ME g	894 8/24/09 TT			
60, ate be ohysici ne buri	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery			
687 certific nding r se as th	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 4 Pregnant at time of death 5	Fetal death 3 Ectopic pregnancy  Other (Specify)	Month Day Year			
, P.O. Box 6876 res that the death certificate signed by the attending phy be detached for use as the d by Physician/M	1 Yes 2 No 9 Unknown 9 Unknown					
bat the etache						
S, P.C juires that an signed ald be deta	Acute pancreatitis		24a. Was an 24b. Were autopsy findings available			
Records, P.( The law requires tha ficate has been signed ; page 2 should be det.	r		autopsy prior to completion of cause of death?			
tal Rection: The certificate extor, page		26.Place of Death (Check only	1  Yes 2 No 1  Yes 2 No			
Vital ysician this cert directo	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 ✓ Inpatient 2 ER/Outs	patient 3 DOA Other; Nursing Ho				
Division of Vital Records, P.O. tal or attending Physician: The law requires that the stater death all Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach artification: To Be Completed by F	27. Manner of Death  28a. Date of Injury (Month, Day, Year)  28b. Tir		Describe how injury occurred			
sion trendi death ctor: y the fi	1X Natural 5 Pending 2 Accident Investigation	1 Yes 2 No	Location (Street and Number or Rural Route Number, City			
Jivis al or A safter al Dire ed in b	28e. Place of Injury - At home, farm, street, factory, office building, etc.  28f. Location (Street and Number of Rural Route or Town, State)					
Division of Vital Records To the Hospital or Attending Physician: The law requivitin 24 hours after death. To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should pedical Certification: To Be Complete	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, and due	to the cause(s) and manner as stated.			
To the H. within 24 To the For complete!	one) 2 Medical Examiner: On the basis of examination and/or inv					
	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) July 9, 2009			
	( and a control of death (then 230)	O.O.IVI.L.	00., 0, 200			
	Laron Locke MD. Assistant Medical Examiner 111	Penn Street, Baltimore, MD 21201				
Stat	31. Date filed (Month, Pay, Year) 2009 32. Registrar's Signature	barked				
Registra	JUL I 11 2008 Steven B.					

DHMH 17 Rev 1/2001 OCME 2006

100 person

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 23, 2009 Month Year 9:00 PM **Physician** June Keith B. Anderson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Hyattsville St. Thomas More N.H. 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1ĂM 2□F June 23,1962 47 222-56-1632 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Evend or must be notified at 1 ☑ Yes 2 ☐ No Director Prince George's Suitland Md. 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 20746 6008 Lucente Ave. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ∐Yes 2 No 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 TYes 21 No Specify: Black Specify: ģ 3 ₩ Widowed 4 Divorced Completed 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Verizon Electrical Tech. is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental Faye Townley Hasting Anderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health al Important: If item 27 is any injury or other trau Md. Lucente Ave. Suitland, 20746 6008 Hasting Anderson (Father) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State June24,2009 Riverdale, Md. Chambers Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Chambers Funeral Home & Crematorium P.A. 5801 Cleveland Ave.Riverdale, Md. 20737 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) HUMAN Immunodaticiancy Vinus / AIDS Revs **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760 Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) □Yes 2□No the 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No has page 2: certificate 2 🗆 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ After this funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: To the Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier seensbury Rd Hyatkv. 110 MD 20181 Name and address of person who completed cause of death (Item 23a) (Type, Print) A. DEVORE MIN 31. Date filed (Month, Day, Year) State 25 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 11.30A M 2009 JUNE AMAEFULE 22 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Howard Columbia Lorien Columbia 8. Date of Birth (Month, Day, Year)
Sept. 28, 1932 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours 1 ☐ M 2 🔀 F Nigeria 76 537-21-8617 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1ÆYes 2□No Columbia MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Nigeria 21045 9640 Basket Ring Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married **Black** 1 □ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Private Industry Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Uzoho Nwaobiara Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9640 Basket Ring Road Columbia, MD 21045 Emmanuel Amaefule/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ukn 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Nkwerre, Nigeria Nkwerre, Imo State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Latney's Funeral Home, Inc 21. Signature of Funeral Service Licensee 3831 Georgia Avenue N.W. Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 70MACH CANCER WITH METASTASES Due to (or as a consequence of): RENAL FAILURE Due to (or as a consequence of) SERSIS Due to (or as a consequence of): DEMENTIA 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

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Medical Certification: To

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certificate

To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the ft.

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death.

: After this certifical funeral director, it

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Modical Examinat mast be refitted at any injury or other traumatic event, the "Modical Examinat mast be refitted at agnee.

Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Examiner Physician/Medical 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

24a. Was an

24b. Were autopsy findings available prior to completion of cause of death?

2 No 1 ☐ Yes 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify)

1 ☐Yes 2 ☐ No

25. Was case examiner? 1 ☐ Yes		medical
27. Manner of	Death	

5 Pending investigation 6 ☐ Could not be

determined

28a. Date of Injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

Natural

2 Accident

3 Suicide

4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

29b. Signature and title of certifier Spence MD

D0023120

JUNE 22HOZOOG

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shakun mala 9650 Supr a

Hospital:

santap Rd

State Registrar

Registrar's Signature 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 2009 11:46 P M June 22, Qayum Ahmad /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Suburban Hospital Bethesda 8. Date of Birth (Month, Day, Oct. 2, 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** <sup>Year)</sup> 1917 Hours 1 □ M 2 🗓 F Months Days 289-60-4456 INDIA 91 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r items 23a or 28a-f show iner nust be notified at 1X Yes 2 No Directo Maryland Montgomery Potomac 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 9920 New London Drive 20854 Pakistan Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married ö 1 ☐ Yes 2 No Specify: Specify: White ģ 3 Widowed 4 □ Divorced "natural" Completed other than "natur 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Home Maker Own Home ulth and Mental Hygi

27 Is marked other

r traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mirza Bashir-UD-Din Mahmood Ahmad Amatul Hai 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 i 9920 New London Drive Potomac, Maryland 20854 Zahir M. Ahmad /Son Item 2 20b. Place of Disposition (Name of cemeterv. crematory or other place) June 29 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If It any injury or o 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Punjab Cemetery Punjab, Pakistan 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Euneral Service 1. MO1315 2222 Wisconsin Ave., N.W. Wash, D.C. 20007 Never) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician Maxillary Cancer 1 year /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-tran Due to (or as a consequence of): Physician/Medical as attending for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy certificate has been signed by the rector, page 2 should be detached Medical Certification: To Be Completed by After this

IUL (P HHMAD Graps 2346 Pro Division of Vital Records, P.O. Box 68760, To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: All completely filled in by the fu

Baltimore, Maryland 21215-0036

1 ☐ Yes 2 ☒No 9 ☐ Unknown	4 ☐ Pregnant at time of death 5 ☐ Other (specify)	Month Day Teal
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
Renal Insuffiency		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown
		24a. Was an autopsy performed? 1 □ Yes 2 No 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical examiner?	26. Place of Death	(Check only one)
examiner? 1 ☐ Yes 2 🛣No	Hospital: 1 → Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Hom	e 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death 1 ☎ Natural 5 ☐ Pending 2 ☐ Accident investigatio	n (Month, Day, Year) Injury Work? n M 1 ☐ Yes 2 ☐ No	8d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		8f. Location (Street and Number or Rural Route Number, City or Town, State)
	hysician: To the best of my knowledge, death occurred at the time, date and place, a miner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.	

D37891

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 29c. License number

June 23, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. Rajvanshi, MD 121 Congressional Lane #407 Rockville, MD

State Registrar

			For State	State	of Mary	land / Depa	artment of rtificate of		d Mental H	• •	nng	22071
			Registrar  1. Decedent's Name (First, Middle	e. Last)			Timeate of	Douth	2. Date of D	Reg. No. L.	000	3. Time of Death
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	/Medic Examin		4a. Facility Name (If not institution				4b. City, Town,	or Location of De			ity of Death	l
	Examin	er	13702 Colgate Wa		,			lver Spri			Montg	omerv
	Funeral		Social Security Number	6. Sex	7. Age (Ir	yrs. last birthday)	If Under 1 Year	If Under 24 H	rs. 8. Date of E	Birth Day, Year)		lace (State or Foreign
	Director		217-55-9192	1 □ M 2 🛣 F		<b>40</b> Yrs.	Months Days	Hours M		30, 1968		Korea
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Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland is and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Evaminer must be notified at		19a. Informant's Name/Relations			19b. Maili	ng Address (Stree	t and Number or	Rural Route Nun	nber, City or Tow	n, State, Zip	Code)
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altımore,	t. Partmer rtant; rjury		4 □ Donation 5 □ Other (S	( )	1		emorial Par		/24/2009	Olney,	Maryla	nd
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Je.	Physician		Immed use (Final dis se or condition		stric C	an ao F						Onset and Death  1 year
	/Medical		resulting in death)			onsequence of):						ı year
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68/	ficate phys s the	dical		d								
×	eath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	utcome of p	regnancy				23d, [	Date of delive	erv
ROX	death le atter ad for u	ciaı	in the past 12 months? 1 □Yes 2 ▼No	4 □ Pre	gnant at tim		☐ Ectopic pregnar ☐ Other <i>(sp</i> ec <i>ify)</i> .	icy			Month	Day Year
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<b>Records</b> ,	aw re	Completed							24a. Wa	as an 24I	b. Were auto	ppsy findings available empletion of cause of
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Vital		Be C	25. Was case referred to medica examiner?	ı				26. Place of I	Death (Check only			
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<u>s</u>	ten leat tor: the	cati	2 ☐ Accident investi 3 ☐ Suicide 6 ☐ Could	not ho		A		]Yes 2 □ No	006 1	(0)		/ D. A. M fa
	= = = =	Certification:	4 ☐ Homicide determ	nined 20e. Plat buil	Iding, etc. (S	At home, farm, st Specify)	reet, lactory, office		City or 7	own, State)	mber or Aura	al Route Number,
_	spital lours neral filled		29a. Certifier 1 🗷 Certifyii	ng Physician: To t	he best of m	ny knowledge, dea	th occurred at the	time, date and pl	lace, and due to t	he cause(s) and	manner as s	stated.
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical		Examiner: On the		amination and/or in						
	Vith Vith Com	Ž	29b. Signature and title of certifie	er \			29c. Licer	ise number		29d. Date sign	ned (Month,	Day, Year)
	5			- Y O	2		D00	63083		Jun	e 22, 2	2009
		Ì	30. Name and address of person									
	Sta	t a	Margit Naomi 31. Date filed (Month, Day, Year)		Registrar's		reet, #S9I	, Baltimo	re, Maryla	nd		
	Registr		JUN 24			B. 100	wed					

		1	For State Registrer	State of M	Maryland / De		tment of H		nd M		iene	09	220	75
		_	Decedent's Name (First, Midd	dle, Last)						2. Date of Death		Year	3. Time of	
	Physicia /Medic		Helen	L.			Ashley			June		00̈̈̈gʻ	10:00	) a <sup>M</sup>
	Examin	_	la. Facility Name (If not institution	-	r)	4	4b. City, Town, or			1010	4c. Count	y of Death		
			105 West 39th				Baltimo	ore, N		21210		n/a	Jaco Ktato	or Foreign
	Funeral		5. Social Security Number	4044 00	Age (In yrs. last birth Y		Months Days	Hours	Min.	8. Date of Birth (Month, Day, Feb 1 1	925	Cou	oundla	"ปัติที่ที่เร
	Director	-	022-28-2448 Usual Residence of Decedent	C	04					100 1 1		Cana	da	
	yland yland		10a. State 10b. Count	•	10c. City, Town								10d. Inside C	•
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936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other then "neturel", or items 23a or 28e-f show important: If item 27 is marked other then "neturel", or items 23a or 28e-f show pry injury or other treumatic event, fro Medical Evant extrausition chilied at anone.	by Fun	11. Marital Status  1 Never Married 2 Ma 3 Nidowed 4 Divorce	If Yes Give	s? () No		as Decedent of Hi Yes, specify Cuba	ispanic Origin, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		ace - Ameri ack, White, ify: V		
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lary	2 should and Men is marke eumatic		19a. Informant's Name/Relation				Address (Street							
	1 and 2 Health Iem 27 i	-	<u>Michael Ashle</u>	ey	20b. Place of		reenwood	a Koa		Greenvil Date	20c. Location			
0	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1 ☐ Burial 2 🎖 Cremation		te Hockes	, crema	Cremato	ry ¦		/2009				3 100
Baltimore,	permit. Pag Department Important: I eny injury c	-	*4 □Donation 5 □ Other  21. Signature of Euneral Service		Company	/	Name and Addres				Hockes			are
Ba	Depa Depa Impo eny ii		mym	nox		Ch	nandler	Funera	al He	ome Wil	m DE 1		Approxima	
	Physician /Medical Examiner	ner	a. Part1nter the disease, sck, or heart failure. Limediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediatecausetimes dotimes disease or injury	a	as a consequence o	pd	lal	inf	ap	etic	) N		Interval Be	
68760,	uires that the death certificate be executed signed by the attending physician and de detached for use as the burial-transit	edicai Examiner	resulting in death) Last	c	as a consequence o	f):	102						1 =20	
O. Box	the death certifica y the attending ph ched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 24 No 9 □ Unknown		2 Fetal death t at time of death		Ectopic pregnancy Other (specify)	<i>'</i>				Date of delivery	very Day	Year
٥.	quires that n signed b	by	Part II. Other significant cond	itions contributing to deat	h but not resulting in	the und	derlying cause giv	en in Part I			bacco use co es 2 <b>X</b> No		the cause of obably 4	
I Records,	: The law requires that the cate has been signed by th page 2 should be detache	Completed								24a. Was a autop perfor 1 Yes	med?	death?	topsy findings completion of 2 No	s available cause of
of Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medi examiner?	Hospital:			Ott			h Check onl or				
of \	Phys this al dir	To	1 ☐ Yes 2X No 27. Manner of Death	1 U inp	1		3 DOA		ursing Ho	ome 5 Aesid 28d. Describe h			cify)	
u C	fter free	tion	1 X Natural 5 ☐ Pen	ding 28a. Date of I (Month, estigation	Day Year) Ir	njury	28c. Injui Wor M 1 □	rk?ື Yes 2□	No					
Division	or Attending after death. Director: After in by the fune	Certification;	3 Suicide 6 □ Cou	lid not be 28e. Place of	Injury - At home, far , etc. (Specify)	m, stre	et, factory, office			28f. Location (S City or Tow	itreet and Nu n, State)	mber or Ru	ral Route Nu	mber,
_	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical Ce	29a. Certifier 1 X Certific (Check only one)	ying Physicien: To the be sel Examiner: On the basi and manner	is of examination and	, death d/or inve	occurred at the ti estigation, in my o	me, date ar opinion, dea	nd place, ath occur	and due to the ored at the time, or	cause(s) and date and plac	manner as e, and due	stated. to the cause	(s)
	To the within To the compl	Me	29b. Signature and title of cert	flier Sho	Lein,	M	29c. Licens		23	39	29d. Date sig	ned (Month	n, Day, Year)	
	7		30. Name and address of pers  Veronica Eps	17	of death (Item 23a) (	Type, P	·, Suite	650,	Bal	timore,	MD 2	1218		
	Sta Regist	ate ar	31. Date filed (Month, Day, Ye	2009 Seneral	jistrar's Signature	al	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) <sup>D</sup>2009 JUNE **Physician** 4:08 AM 25 MARY EMMA ALLEN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CARROLL SYKESVILLE COMMUNITY FAIRHAVEN RETIREMENT Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4/22/1914 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 □ M 2 👿 F 219-22-9158 95 MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 1 √Yes 2 No CARROLL SYKESVILLE Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21784 7200 THIRD AVENUE Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🗶 No 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify Specify: WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) **EDUCATION** Elementary/Secondary (0-12) College (1-4or 5+) MUSIC TEACHER 18. Mother's Name (First, Middle, Maiden Surname)
BERTHA STEINACKER 17. Father's Name (First, Middle, Last) Be LOUIS ST. CLAIR ALLEN ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10068 WHITWORTH WAY, ELLICOTT CITY, MD 21042 PHILIP JOERDENS, III/NEPHEW 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State BALTIMORE, MD LOUDON PARK CEMETERY 15, 2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821, 327 W. KING ST., MARTINSBURG, WV 25402 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Emen disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner ri any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 → 10 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s performe certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 1 No After this certification, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∐Ko 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State

31. Date filed (Month, Day, Registrar

(Check only one)

29b. Signature and title of cer

Registrar's Signature parke

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MIN

DHMH 17 Rev 1/2001

DIL

within 24

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Buckmaster 1158 PM William 24 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner alvert Hospital Frederick ( alvert Memorial Mince If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year, Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**X** M 2□ F 01/26/1924 Maryland 85 Director 218-16-0109 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 ☐ Yes 2 No Director Calvert Owings 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatte event, the Medical Examiner must be n U.S.A. 20736 1480 Skinners Turn Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 white Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) construction 11 carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Brady Maurice Isac Buckmaster Edith Pear1 မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1480 Skinners Turn Road, Owings, MD Hilda Mae Buckmaster, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Harmony Cemetery 06/30/2009 Owings, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licer se Rausch Funeral Home, P.A. uboel 8325 Mt. Harmony Lane, Owings, MD 23a. Part1. Enter the discusse, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hent failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine executed burial-tran and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician certificate be Physician/Medical the as IF FEMALE: use If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death Month Day Year p in the past 12 months? ☐Yes 2☐No detached the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I 2 100 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? res 22 No has certificate 1∏ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 Director: After that in by the funeral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death Certification: (Month, Day Year) Injury Attending 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined or A 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hospital or within 24 hours at To the Funeral D completely filled

UL

State Registrar

29b. Signature and title of certifier

67594

trina

Frederick,

29c. License number

29d. Date signed (Month, Day, Year) 25,2009

20678

Name and address of person who completed cause of death (Item 23a) (Type, Print) Hepp, MD

Hospital 100

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 17 Amended Last name7/1/09 Retrificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 2009 IVY F. BOSLEY June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ASTO TAIDOT K Memorial HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (În yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 1 F 2/15/1933 VIRGINIA Director 218-30-6187 77 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Modical Examit or most be notified at 1¥ZYes 2 ☐ No Director **TALBOT** ST. MICHAELS **MARYLAND** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 106 B. CONNER ST. 21663 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married  $80sleq_{\gamma}\text{ TV}\gamma$  Baltimore, Maryland 21215-0036 1 ☐Yes 2¥ No by Specify: Specify 3X Widowed 4 ☐ Divorced WHITE Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **HEALTH CARE** CAREGIVER 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CARPENTER 2 should be fi and Mental H OSCAR C. CARPER LACIE S. SANDERS ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other tra 106 B. CONNER ST., ST. MICHAELS, MD 21663 TERRY CARPER / SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/30/2009 CAMBRIDGE, MD MID SHORE CREMATION CENTER 22. Name and Address of Facility 21. Signature of Funera MID SHORE CREMATION CENTER, 2272 HUDSON RD., CAMBRIDGE, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Exami burial-trans resulting in death) Last Due to (or as a consequence of): physician as the burial-P.O. Box 68760, certificate be Physician/Medical use as attending IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) □Yes 2□No detached 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 □Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1□Yes 2No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29b. Signature and title of certifier Dø065656 M -30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , 219 South was T9960 32. Registrar's Signature 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Clarence Sydney Bradley June 26 2009 8:02 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Mallard Bay Care Center Dorchester Cambridge Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Maryland 213-22-4819 81 July 10, 1927 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State MD Dorchester Cambridge 1XYes 2 □ No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 520 Glenburn Avenue 21613 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 XYes 2 I If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🗆 No 1 ☐ Yes 2 🛂 No Specify. Specify: white WWII 3 Widowed 4 XDivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) collections agency supervisor 12 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Clarence Bradley Lena Elizabeth Saunders 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Brian K. Burton O. Box 53, East New Market, MD 21631 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Salisbury Crematory 6/27/09 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final month brain TUMOr disease or condition resulting in death) Due to (or as a consequence of) 6 months Pancreanic Dile to for as a consequence of Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No 26. Place of Death (Check only one)

permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" ~~ any injury or other traumatic excess. Physician /Medical Examiner To the Hospital or Attending Physiclan: The law requires that the death certificate be executed

Box 68760,

Division of Vital Records, P.O.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f shov

Director

Funeral

þ

Completed

7 Is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at

attending physician and for use as the burial-transit cate has been signed by the page 2 should be detached certificate funeral director, this After t

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu State

Sequentially list conditions, if any, leading to infine data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 25. Was case referred to medical Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2∭ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Umbedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

HOU54973

30 Mame and address of person who completed cause of death (Item 23a) (Type, Print) lohnson Bramble 100 atricia

31. Date filed (Month, Da

29a. Certifier (Check only

Cambridg, MD

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 05<sup>Day</sup> Month 07 **Physician** 0645 Brake R. William /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** ALLEGANY CUMBERLAND
If Under 1 Year | If Under 24 Hrs. WMHS BRADDOCK CAMPUS Birthplace (State or Foreign Country)
 MD 8. Date of Birth (Month, Day, Oct 2, . Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min 1 XM 2 ☐ F 214-05-8859 91 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Examination ust be mutthed at 1 □Xes 2 □ No Cumberland MD Allegany Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21502 USA 13911 Uhl Highway SE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify þ white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 th and Mental Hygiene.

7 is marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) Allegany Co. Bd. of educator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida B. Brake Benjamin S. Brake ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is n any Injury or other traunonce. 21 Prospect Square MD 21502 Cumberland Greg Getty attorney Date 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 7/7/2009 Scarpelli Funeral Home, P.A. MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Fureral Service License 108 Virginia Avenue: Cumberland, MD 21502 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or co. dinon resulting in d-ath) Physician Stive 200 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) Division of Vital Records, P.O. icate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 🗷 No 1 ☐Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Pruneral Director: A 2 Accident filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/oy investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical completely (Check only one) and manner stated within 2 the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar 30. Name and address

31. Date filed (Month, Day, Year,

Gamar

DHMH 17 Rev 1/2001

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son who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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umberland

Maryland

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Jose Fredy Diaz Cedillo	State of Maryland / Department of Health and Mental Hygiene	2009
1- For State	Certificate of Death	2003

ose Fredy Diaz		dillo 1- For State Registrar	State of Mary		artment of rtificate of		and Me	ental Hy		eg. No.	009	2208
Physici ledical Exami		1. Decedent's Name (First, Mi Jose Fredy		lo				1	2. Date of Dea Month June 20,	Day Year		of Death 7 hrs
		4a. Facility Name (if not institute 20500 Georgia Ave	ution, give street and r		4	b. City, Town		on of Death		4c. County of Montgom		
Funeral Director		5. Social Security Number None	6. Sex	7. Age (In yrs.	last birthday) 29 Yrs.	If Under 1	Year If L	Inder 24Hrs.	1	rth(MM/DD/YYYY)	9. Birthplace (	State or onduras
Varyland <b>28a-f show</b> any Latonce,	٥r	Usual Residence of Deceden  10a, State 10b, Cour  Md MO		Bro	Town or Location	e		-1				side City Limits Yes 2 No
th the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number 3201 Damasc	us Rd.			10f. Zip Coo 208		<u> </u>		10g. Citizen of Wha Hondur		
er death with th , or items 23a r must be noti	Funeral				If Ye		ban, Mexi	Origin? (Specan, Puerto F	_	o- 14. Race - White,	American India etc.	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho imatic event, the Medical Examiner must be notified at once	ompleted by	15. Decedent's Education (S	or Dates: Specify only highest gr		16a. Decedent during mo	's Usual Occ st of working	upation (G		ork done	16b. Kind of Bus	iness/Industry	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 bepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "injury or other traumatic event, the Medical.	Be Comp	9th 17. Father's Name (First, Mid Abraham Dia			Lai	oor				Lands Maiden Surname) Cedillo	cape	
MD 21; 12 should b th and Men 127 is mar umatic eve	Tol	19a. Informant's Name/Relation Rigo Diaz/B			3201	Danab	000 1		ural Route Nu OKEV:11	mber, City or Town		
Baltimore, MD permit. Pages 1 and 2 shu Department of Health and Important: If item 27 is injury or other traumat		4 Donation 5 Other			Place of Disposi crematory or oth Genera	er place) 1. Ceme	tery	06/	Date 27/09	20c. Location - Hondi	ıras	
	-	21. Signature of Funeral Serv	me XX		30		h St	. NE W	ash. D	Rhines Fu .C. 20017	7	HOME
Physician /Medical Examiner	0	23a. Part I. Enter the disease failure. List only one car Immediate Cause (Final dise or condition resulting in death	use on each line. <sub>ase a.</sub> Multiple Ir			e mode or dy	ing, such	as cardiac or	respiratory ai	rest, shock, of flea	Betw	een Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cat (Liberage of highly that influits	b	s a consequence								
50, te be executed ysician and burial - transit	al Exar	events resulting in death) La	d	s a consequence								
60, ate be ex hysician e burial	Medical	UNPENDED  IF FEMALE:		9boerFH,6/ s, outcome of pre		,MbCb				23d. Date of	delivery	
on of Vital Records, P.O. Box 68760, and pysician: The law requires that the death certificate be ar. After this certificate has been signed by the attending physici he funeral director, page 2 should be detached for use as the buri	ıysician/M	23b. Was decedent pregnant past 12 months?	4 Pre	e birth gnant at time of d known	hoth -	al death ner (S <i>pecify)</i>	3Ec	topic pregnar	ncy	Month	Day	Year
s, P.O. E ires that the c signed by the	ed by Phy	Part II. Other significant con	nditions contributing	g to death but not	resulting in the u	nderlying cau	ise given i	n Part I.	1 Ye	tobacco use contril es 2 No 3	Probably 4	Unknown
of Vital Records, ng Physician: The law requir ther this certificate has been s meral director, page 2 should l	Completed								1 ✓ Yes	opsy p formed? d	Vere autopsy fir rior to completion eath?  Yes	ndings available on of cause of
Vital Rechysician: The lathis certificate la director, page	o Be (	25. Was case referred to med examiner?  1 ✓ Yes 2 No	Hospital:	Inpatient 2	ER/Outpatient		lace of De Other	ath (Check of		Residence 6	Other: Scene	
ion of \ tending Phy eath. tor: After th		27. Manner of Death  1 Natural 5 F	28a. Da (Mo Jun 20 nvestigation	ate of Injury oth Day Year) 0, 2009	28b. Time of Ir 0212 hrs	· ·   .	Injury at V	No S	<sup>28d.</sup> Describe Subject dri vehicle acc	how injury occurre ver of vehicle cident	involved in	motor
Division  Division  The Hospital or Attendia  Fin 24 hours after death  the Funeral Director: A  apletely filled in by the fu	Certification:	3 Suicide 6 (	Could not be determined (Special	ace of Injury - At l	eet				or Town, 20500 Georg	(Street and Number State) gia Avenue, Broo	okeville, MD	te Number, City
D To the Hospital within 24 hours To the Funeral completely fillee	Medical	29a. Certifier (Check only one) 2 Medical  29b. Signature and title of ce	g Physician: To the b Examiner:On the bas and manne	is of examination	dge, death occur and/or investigat	ion, in my op	e, date an inion, deat cense nun	th occurred a	due to the car t the time, dat	use(s) and manner e and place, and d	ue to the cause	
DV	2	Theoden	M. King	& JA	, w.	- 1	.C.M.E.		OCME	June 20, 20		,
		<ul> <li>Name and address of per Theodore M. King,</li> </ul>		au of death (Ite stant Medical		111 Penr	Street,	Baltimore	e, MD 2120	01		
S Regis	tate	11 ( 11 ) 7 (	2009	Registrar's Signa	1. par	2						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day JUNE 21", **Physician** 200<sup>Y</sup>9<sup>ar</sup> COLEMAN MARY HELEN 0114 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia HOWARD 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Mar . 7, 9. Birthplace (State or Foreign **Funeral** 90 Hours Min. Maryland 1 M 2 W 212-36-8027 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Exameter must be notified at MD Director Howard Columbia 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7364 Oaklyn Mill Road 21046 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐Yes 2 ☐No Specify: 3 Black Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7; th and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) 8th Housewife Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter L. Dorsey Mary E. Johnson ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s Health e Deborah Coleman (Daughter) 7364 Oaklyn Mill Rd, Columbia, MD 21046 ortant: If item 27 injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1

☐ Burial 2 ☐ Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. Guilford Mem Park 6/26/09 Columbia, MD 4 Donation 5 Other (Specify) <sup>₫</sup> 21. Signature of Funeral Serve Liven. 22. Name and Address of Facility SNOWDEN FUNERAL HOME, 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Heart Attack /Medical Due to (or as a consequence of) Examiner Cardiac Arrythmia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine Atherosclerosis and burial-tra resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Hypertension the t as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy ģ in the past 12 months? Month Day Year 5 Other (specify) the 1 ☐ Yes 2 No 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page certificate perform 1 □ Yes 2X No 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 A ER/Outpatient 3 DOA funeral dir Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

be executed Box 68760 P.0. Division of Vital Records, Physician:

72 hours after death

Maryland 21215-0036

Baltimore,

Pages 1

After this al or Attending P s after death. I Director: After I filled in by the To the Hospital within 24 hours a the Hospital

> State Registrar

Medical

determined

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

D044763

6/21/09

who completed cause of death (Item 23a) (Type, Print) 30. Name and address of perso

and manner stated.

Martinez, M.D. 5755 Cedar Lane, Columbia, MD 21044

31. Date filed (Month, Day, Year, 2009

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifie

			State of Maryland / Do	partment of Health and M	-	_	
			101	ertificate of Death		g. No. 200	0 22067
			Decedent's Name (First, Middle, Last)		2. Date of Death	the ball of	3. Time of Death
	Physicia /Medic		William Combs		June 22,	2009 Year	5:22 a M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	)
-			Kline House Hospice	Mt. Airy		Frederic	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 185–16–1820 7. Age (In yrs. last birthda 87 Yrs.	y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, 09/19/19	Year) 9. Birth	nplace (State or Foreign untry) PA
			Usual Residence of Decedent		0)/1)/1	721	IA
	arylan show	<u>_</u>	10a. State 10b. County 10c. City, Town or				10d. Inside City Limits
	he Ma	ecto	Maryland Frederick Frederick		1		¥∏Yes 2∏No
	with t	Dir	10e. Street and Number 2410 Ellsworth Way, Apt 2C	10f. Zip Code 21702	10	g. Citizen of What Cou	intry?
	ms 23	Funeral Director		3. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	USA 14. Race - Amer	rican Indian,
ဖ	or iter		1 Never Married 2 Married 1X Yes 2 No		Rican, etc.)	Black, White	
003	ural",	d by	Year or Dates Nov 1945	1 □ Yes 2 □ No Specify:			
21215-0036	"natu	Completed by	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of worki n. DO NOT use retired)	ng 1	6b. Kind of Business/I	ndustry
212	withii jiene. r than	dmo	Elementary/Secondary (0-12)   College (1-4or 5+)	arch and Developmen	nt	Ball Beari	ings
פר	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. I sand Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, its five fice its able in number of filed 2.	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name			8-
<u> </u>	ould by Menta arked atic e	To E	John Combs	Gertrude	Sargent		
Jar	and 2 should ealth and Mer n 27 is marke ner traumatic			illing Address (Street and Number or Rura		-	•
e,	ges 1 and 2 should be filed within 72 hours after death with the Marylan to fleatht and Mental Hygiene.  10 fleath and Mental Hygiene.  11 fleat 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, its Medical Examination and its of other traumatic event.	8		10 Ellsworth Way, A		Frederick, Oc. Location - City or T	
Baltimore, Maryland	permit. Pages 1 and Department of Heal Important: If item 2 any Injury or other once.		1 Burial 2X Cremation 3X Removal from State cemetery, c	rematory or other place)  1 Crematorium 06/30		•	
	ariti. Paritme ortan Injur						ch, Virginia
m	an ja per		M01255	22. Name and Address of Facility EDWARD SAGEL FUNERA 1091 Rockville Pike	AL DIRECT Rockvi	TION, INC. Llle. Marvl	and 20852
			23a. Part 1. Whiter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.				Approximate Interval Between
Car P	hysician		Immediate Cause (Final disease or condition Metastatic Liver	Cancer		1	Onset and Death  10 years
and the	/Medical Examiner		resulting in death)  Due to (or as a consequence of):				
In.		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  b. Due to (or as a consequence of):				
-	d d ansit	Examiner	cause. Enter Underlying Cause Usease or injury that initiated events  c.				
oʻ	an an rial-tr		resulting in death) Last Due to (or as a consequence of):				
8760,	The law requires that the death certilicate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit.	lical	d				
× 68	ding p	/Mec	IF FEMALE:				
Вох	attending p	Physician/Med	Dramont at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deli Month	very Day Year
0	the d	ysi	1   Yes 2   No 4   Pregnant at time of death 9   Unknown	O Cities (specify)			
o,	ines that the de signed by the a d be detached f	by PI	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
g	w require s been sig should b	edk	Renal Insufficiency		1 ☐ Yes	s 2 <b>X</b> No 3∏ Pro	obably 4 Unknown
ေင	has be	Completed			24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
<u>ا</u> ۳	cate h	Con			perform 1 ☐ Yes 2	ed? death?	2 □No
<u> </u>	r nysician: The la r this certificate had ral director, page 2	Be	25. Was case referred to medical examiner?	26. Place of Death			
ō	Attending Proystolan: It death. ector: After this certifics by the funeral director, p	1: To	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	me 5 ☐ Resider 28d. Describe hov	nce 6X Other (Spec	eity) Hospice
<u></u>	ath. T: Afte	atio	1X□ Natural 5 □ Pending (Month, Day, Year) Injur 2 □ Accident investigation	y Work? M1 □Yes 2 □No			
Division of Vital Records,	after death after death Director: I in by the	ertification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
۵ :	urs after or are are are are are are are are are ar	O				( )	
3	no the hospital of A within 24 hours after To the Funeral Direct completely filled in by	Medica	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, de (Check only one)  Medical Examiner: On the basis of examination and/or and manner stated.				
4	vithin Fo the	Med	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month	ı, Day, Year)
	2		/ Mun hun /n	D47101	J	une 23, 20	09
-			30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)			
	-0:		Dr. Wing Tam 195 Thomas Johnson Dri	ve, Frederick, Mary	land 21	702	
	Sta Registr			all.			

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of N	/larylan		artmen rtificate	t of H	lealth a	and M	lental l	Hygie Reg	ene 21	009	3 2	208
	Dhysisi		1. Decedent's Name (First, Middle, Las	_							2. Date of	Death	Dav	Year	3. Time o	
	Physicia /Medic		Alexandra Diamor								June	23,	<sup>Day</sup> 2009		9:25	рМ
	Examin	er	4a. Facility Name (If not institution, give		er)				Location				4c. County			
-			Holy Cross Hospit  5. Social Security Number 6. S		Ago (In ura I	last birthday)	If Under		Spr	_	8. Date of	F Rieth	MC		mery	or Foreign
н	Funeral Director			_ M 2⊠F	99	Yrs.	Months	Days	Hours	Min.	(Month	Day, Y.	1909	Cou G1	place (State ntry) Ceece	di i dieigii
	ТО		Usual Residence of Decedent						1							
	arylan show	_	10a. State 10b. County		10c. City	y, Town or Lo	cation								10d. Inside 0	
	Ba-f	ecto		tgomery		Silv	er Sp		Ī							s 2 🔼 No
	with the	늅	10e. Street and Number 8505 Springvale 1	be o			10f. Zip					10g	. Citizen of V US		ntry?	
	ns 23	Funeral Director	11. Marital Status	12. Was Deceder	nt Ever in U.	S. 13.			ispanic Ori	igin? (Sp	ecify Yes o	r No-			can Indian,	
ယ္	or iter	교	1 ☐ Never Married 2 ☐ Married	Armed Forces 1 ☐ Yes 2X	s?		Was Deced				Rican, etc.	)		k, White,		
03	ral", c	d by	3x Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	s:		1 □ Yes 2	<b>ZX</b> ∐ No	Specify:				Specify	· Wh	nite	
21215-0036	72 ho	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)		16a. Dece (Give	dent's Usua kind of wor DO NOT us	al Occupa rk done o	ation during mos	t of worki	ing	16	b. Kind of Bu	usiness/Ir	ndustry	
121	vithin ene. than	ld l	Elementary/Secondary (0-12)	College (1-4o	or 5+)		<i>DO NOT us</i> l <b>emake</b>		)				Own F	Iomo		
d 2	filed v Hygie ther		17. Father's Name (First, Middle, Last)			110111	elliaxe	1	18. Mothe	er's Name	e (First, Mic	ddle, Ma	iden Surnam			
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ary	shou and M s mar umat	-	19a. Informant's Name/Relationship (										City or Town,			
	es 1 and 2 aof Health a of Health a fitem 27 is rother trau		Maria D. Chomeau,	/Daughter		1				oloni	ial Be	each	, VA 2	22443	3	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Medical Exp. it at interpretable and once.		20a. Method of Disposition  1 ■ Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specification 1)			Place of Disponentery, crein Deme					Date 11y 3, 2009	,	c. Location - nnapo]			and
Balti	permit. Departm Importa any Inju		21. Signature of Funeral Service Licen		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	- 1				ins	Funer	ral	Home 1	Inc.		
			23a. Part 1. Enter the disease, or comp	plications that caus	sed the death								lver S t,	prii	Approxima Interval Be	
- San San San San San San San San San San	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Acute	Left		llar	Hemo	rrhag	ge					Onset and	Death
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5	cuted	Examiner	Cause (Disease or injury that initiated events	С.												
,092	ie exe ian a urial-t	Ĕ	resulting in death) Last	Due to (or a	as a consequ	uence of):										
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9 X	certifi nding se as	Physician/Med	IF FEMALE:	23c. If yes, outcon	ne of pregna	ancv							and Do	to of dolin	1071	
Вох	leath atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2★ No	1 ☐ Live birth	h 2 🗆 Feta	l death 3[	☐ Ectopic p☐ Other (sc		у					te of deli onth	Day	Year
P.0.	t the c by the achec	hysi	9 Unknown	9 🗌 Unknow	n											
	w requires that the de been signed by the should be detached	by P	Part II. Other significant conditions of	ontributing to death	n but not resu	ulting in the u	nderlying c	ause give	en in Part I		23e. I	Did toba	cco use cont	ribute to	the cause of	death?
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	8		1 Kenb	Joth												
			30. Name and address of person who Nejib Siraj, MD	1500 F	orest	Glen		Sil	ver S	Sprin	ng, Mi	D 20	910			
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DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

		For					artment of F		Mental Hy	gien	9		
		= State Registrar AMEND#23			5/09,BMW,	Moob Ce	rtificate of	Death	T	Reg. No	. 200	9,220	8.5
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/Medic	al	MARY		HERINE	DENN]	<u> </u>	4h City Tourn	- Leasting of Dooth		19,	2009 c. County of Dea	7:15 A	
Examin	er	4a. Facility Name (If not instit			mper)		Kensingt	r Location of Death	1	40	Montgo		
	- 4	5. Social Security Number	6. S		7. Age (In vrs	. last birthday		If Under 24 Hrs.	8. Date of Bi	rth		rthplace (State or For	eign
Funeral Director		577-48-0281	1	□M 2 <b>X</b> F	93	Yrs.	Months Days	Hours Min.	May 5	ay, Year	16	Ohio	
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rylan show I at	_	10a. State 10b. Co	unty		10c. C	ity, Town or L	ocation					10d. Inside City Lin 1 ☐ Yes 2  X	
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or 20	Director	10e. Street and Number					10f. Zip Code				itizen of What C	country?	
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after death with the Maryland or Items 23a or 28a-f show miner must be notifled at	Funeral	11. Marital Status	Marriad	Armed Fo	edent Ever in torces?	J.S.   13.	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puert	o Rican, etc.)	0-	Black, Whi	ite, etc.	
rs aft	by F	1 ☐ Never Married 2 ☐  3(3) Widowed 4 ☐ Divo		1 XYes If Yes, Giv Year or D	ve lates: WW-]	гт	1 ☐ Yes 2 🗷 No	Specify:			Specify.Whi	te	
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should be filed within 72 hours ind Mental Hygiene. s marked other than "natural", umatic event, the Medical Exa	2	Emmet Edward	Brac	ly 				Ethel	Kalaher	<u> </u>			
and 2 sho ealth and n 27 is m		19a. Informant's Name/Rela Bernard G.			/Son		ing Address <i>(Street</i> 19 N. Har						
s 1 a of Hez		20a. Method of Disposition				Place of Disp	osition (Name of ematory or other place	ce) Tana	Date	20c. l	Location - City o	r Town, State	
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Ser	vice Licen	isee		2	2. Name and Addre Francis J 500 Unive	ss of Facility Collinersity Bl	s Funer	al H Sil	lome Inc	ing, MD 2	090
7.51		23a. Part1. Ener the diseas shock, or heart failure.	e, or com	plications that o	caused the dea						1	Approximate Interval Between	
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7 = E	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,	Due to	(or as a conse	equence of):							
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ding Ph J. After th funeral		27. Manner of Death 1X Natural 5 □ Pe	ending	28a. Date (Mon	of Injury oth, Day Year)	28b. Time Injury	Wor		28d. Describe	how inj	ury occurred		
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spital ours a neral filled		29a. Certifier 1 XCer	tifying Ph	ıysiclan: To the	e best of my kr	nowledge, dea	th occurred at the ti	me, date and place	, and due to th	e cause	(s) and manner	as stated.	
To the Hospital or Attending Physician: The law requires that the death certificath hours after death.  To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	Medical			miner: On the b			investigation, in my						
withir To th	Me	29b. Signature and title of ce	ertifier	2/	,		29c. Licens	se number		29d. D	ate signed (Mo	nth, Day, Year)	
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(0)		30. Name and address of pe	rson who	completed caus	se of death (Ite	om 23a) (Type AMC , 50	o, Print)  O IRVING	STREET N	, WASH	INGT	ON,DC 2	0422/688	
Sta Registr		31. Date filed (Month, Day, JUN 2		19	Registrar's Sign	ature ba	wed.						

09-04913 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Gregory Drozynski 1- For State Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Day June 21, 2009 1444 hrs Medical Examiner Gregory Drozynski 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1c. County of Death Calvert Solomons 14260 Calvert Street 9. Birthplace (State or If Under 24Hrs. 8. Date of Birth (MM/DD/YYY) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** Foreign Country) Maryland Hours Months Day Director 07/31/1980 1 X M 2 F 28 218-17-8720 Usual Residence of Decedent 10d. Inside City Limits 10c, City, Town or Location 10b. County 1 Yes 2 X No items 23a or 28a-f show Solomons Calvert Maryland Pages 1 and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-7 sho must be notified at once Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20688 14260 Calvert Street 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married Yes 2 X No Specify: White Yes 2 X No specify. 3 Widowed Give Year Divorced <u></u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) event, the Medical Itimore, MD 21215-0036 Restaurant 2 Chef 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joan Marie Luddy Robert Wayne Drozynski Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 8 Seventh Ave., Brunswick, MD 21716 Robert Wayne Drozynski/ Father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition crematory or other place) nt of H 1 X Burial 2 Cremation 3 Removal from State Department of Important: I June 26, 2009 Port Republic, Maryland Chesapeake Highlands 4 Donation 5 Other Specify: 22 Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service License P.O. Box 600, Lusby, MD 20657 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line /Medical Death a. Asphyxia Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of) ner if any, leading to immediate cause. Enter Underlying Cause Exam (Disease or injury that initiate) Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Sa UNPENDED AMENDED attending physician or use as the burial cian/Medi Division of Vital Records, P.O. Box 68760. 23d. Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Year Live birth 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown has been signed by the att. 2 should be detached for Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 ✔ No 3 Probably 4 Unknown Completed 24h Were autopsy findings available 24a Was an prior to completion of cause of autopsy performed this certificate Yes 2 V No 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be Other<sub>4</sub> examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene 1 ✓ Yes No 28a. Date of Injury FOUND: 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury After 27. Manner of Death Subject placed plastic bag over head and Certification FOUND: within 24 hours after death.

To the Funeral Director: A completely filled in by the fun Natural 1 Yes 2 ✓ No 5 Pending hanged self Jun 21, 2009 1348 hrs Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 V Suicide Could not be or Town, State) 14260 Calvert Street, Solomons, MD (Specify) Single Family Home Homicide 29a. Certifier 1 [ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

31. Date filed (Month, Day, Year) State IIIN 24 Registrar

Patricia Aronica-Pollak MD.

29b. Signature and title of certifie

Registrar's Signature

Assistant Medical Examiner

29c. License number

O.C.M.E

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

June 22, 2009

30. Name and address of person who completed cause of death (Item 23a)

and manner stated

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 8:04 A M John Gregory Dubyak 2009 6 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 120 Old Landing Rd. Ocean City Worcester 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1**X** M 2□ F Months Days Hours Min 42 216-70-8661 1-16-1966 Md Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, It a Marical Examiner must be notified at 1 Yes 2 □ No Director Md Worcester Ocean City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 120 Old Landing Rd. 21842 US Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 21 No Specify Specify: White ş 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HVAC Tech HVAC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked 1 any injury or other traumatic ev John Dubyak Mary Davis ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Joanne Dubyak/ mother 120 Old Landing Rd. Ocean City Md. 21842 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/25/2009 4 ☐ Donation 5 ☐ Qther (Specify) Cape Henlopen Crem. Frankford De. 22. Name and Address of Facility The Burbage Funeral Home Service Licenses 108 William St. Berlin, Md. 21811 23a. Part 1. Enter meldisease or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Liver failure **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760, certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Year 5 ☐ Other (specify) signed by the a the detached f P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Alcohol Abuse Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 □Yes 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 587 55 June 25, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glenn Arzadon, MD 9714 Healthway BA 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature 5 Registrar

DHMH 17 Rev 1/2001

09-05202 Olga Francis Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Francis		- For State	ate of Maryland		ment of icate of		wentai m		eg. No.	200	9	220
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cal Examir		OLGA  4a. Facility Name (if not institution		ANCIS	34	b. City, Town, or L	ocation of Death	July 2, 20		inty of Death		
		2102 Fairland Road	i, give on out and members,			Silver Spring				gomery		
Funeral		5. Social Security Number	6. Sex 7. Ag	je (In yrs. iast i		If Under 1 Year Months Days	If Under 24Hrs			9. Birth Foreign	nplace (State Intry) AM	e or AIC. A
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any	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Location	on					10d. Inside	
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Maryland 28a-f show d at once.	Director	10e. Street and Number		1		10f. Zip Code				of What Coun	itry?	
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hysician		23a. Part I. Enter the disease, o	r complications that cause	ed the death. D	o not enter t	he mode of dying,	such as cardiac	or respiratory a	rrest, shock,	or heart	Approxin Between	nate Interva
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LIVISION OF VICAL RECOVES, tall or Attending Physician: The law requires and refered and requirements and pirecent. After this certificate has been selled in by the funeral director, page 2 should the	cati	2 Accident Inv	vestigation	f Injury - At ho	me, farm, str	eet, factory, office	building, etc.			d Number or F	Rural Route	Number, Ci
lal or is after al Dir	Certification:		ould not be termined (Specify)					or Tow	n, State)			
Hospi 24 hou Funer		29a Certifier	Physician: To the best of	f my knowledg	je, death occ	urred at the time,	date and place,	and due to the c	ause(s) and	manner as st	ated.	1
To the F within 2 To the F	Medical	one) 2 Medical Ex	xaminer:On the basis of e and manner state	examination ar	nd/or investig	ation, in my opinio	on, death occurre	ed at the time, d	ate and place	e, and due to	the cause(s	
3-PEND	¥ e	29b. Signature and title of cert					nse number		- 1	ate signed <i>(N</i> 3, 2009	riorith, Day,\	ear)
		June 12					S.M.E. 		July .			
		30. Name and address of pers	on who completed cause on sistant Medical Ex		23a) 111 Penn	Street, Baltin	nore, MD 21	201				
	L				A	Week Baltin	,010,1110 2 17					
	State	31. Date filed (Month, Day, Yea	7 2009 Den	strar's Signatu	7. 1996	No. and						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Shirley J. Henschel 200 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MATHINGTON ADVENTITY MODTGOMER HOSPITAL PARK MAKOMA Social Security Number 7. Age (In yrs. last birthday) 82 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec.3,1926 6. Sex 9. Birthplace (State or Foreign **Funeral** Hours 565-20-1108 1 □ M 2 🛣 F Months Days Min. Illimois Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: if them 27 Is marked other than "natural"; or items 23a or 28a-f show any inJury or other traumatic event, in Modes Examine must be notified. Maryland Montgomery Silver Spring Funeral Director 1 □Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9306 Wyre Avenue 20901 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo White ģ If Yes, Give Year or Dates: Specify Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Caterer Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sydney Mandel Bess Hersch 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Densmore Henschel -busband 9306 Wyre Avenue Silver Spring, Maryland 20901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cemetery 7/1/2009 Arlington, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, PA Maryla<u>nd20705</u> 23a. Part 1. Euter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Anteroscusion CARDIO VASCULAR **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, flary, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or): Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) by the a ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an 2 100 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 NER/Outpatient 3 DOA 27. Manne o Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation s after death.

I Director: A
id in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) m Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600

State

Registrar

31. Date filed (Month, Day,

JUN

Year)

24

SW

32 Registrar's Signature.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 20<u>09</u> Month Year **Physician** June 23, Alexander Halako 2:35 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 8. Date of Birth (Month, Day, You Sept. 9, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6, Sex **Funeral** Year) Months Days Hours 1 M 2 □ F 210-01-0912 92 1916 Czechoslovakia Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location r than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 K No Director Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 1 413 Northwest Drive 20901 USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White δ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Self-Employed Magazine Distribution permit. Pages 1 and 2 should be filed beardment of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Halako Anna Yenchi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Alexandra J. Paolucci/Daughter 43671 Sunny Ridge Lane, Hollywood, MD 20636 Baltimore. 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date June 29 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 2009 4 Donation 5 DOther (Specify) Silver Spring, Maryland 22. Name and Address of Facility. Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a. Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Urinary Tract Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed Pancytopenia physician and s the burial-trans Due to (or as a consequence of): 68760 Physician/Medical requires that the death certificate attending properties for use as 33 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Ye ar 4 ☐ Pregnant at time of death 5 Other (specify) ed by the a 1 Tyes 2 No. Ö 9 Unknown σ. signed k I be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy performed page, this certificate 1 ☐Yes 2 ☐ No 2 X No 1 ☐ Yes To the Hospital or Attending Physician; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1∐Yes 2XINo Other: 4 \sum Nursing Home 5 \sum Residence 6 \subseteq Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ After thi funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: completely filled in by the f 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \( \sum \) Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10 D68150 June 23, 2009

State Registrar

DHMH 17 Rev 1/2001

Nejib **Mra**j,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Begistrar's Signature

MD

1500 Forest Glen Road, Silver Spring, MD 20910

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 09:19 **Physician** 24 2009 6 James M. Horner /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ocean City Worcester 4400 Coastal Hwy. Unit 305 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Yea 9/16/1926 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days 1**X**] M 2□ F 82 PA 209-12-6822 Director Usual Residence of Decedent 10d. Inside City Limits 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a State 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director Dauphin Harrisburg 10g. Citizen of What Country? 10e. Street and Number ō USA 17111 23a 6418 Taunton Rd. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? or items, 11. Marital Status Black, White, etc 1X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ KNo Specify: white ģ 3 X Widowed 4 ☐ Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) than College (1-4or 5+) CAT Driver CAT h and Mental Hygier 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be William Horner Caroline Taylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kathy Garland/ daughter 6418 Taunton Rd., Harrisburg, PA 17111 Health a Department of Heal Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Blue Ridge Mem. Gdn 6/29/2009 Harrisburg, PA 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home Berlin, MD 21811 108 William St., inta Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart allure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part 1, Enter the Immediate Cause (Final disease or condition resulting in death) **Physician** OR ONTRY SEVERAL YRS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duallo (or as a consequence of) Examiner be executed burial-transit and Due to (or as a consequence of) attending physician for use as the buria Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) signed by the a 1 ☐Yes 2 ☐ No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💇 Unknown PARKINSONISM director, page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐ Yes 2 No 1 ∐Yes 2 🎛 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Residence t Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral d 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 Natural 2 Accident 5 ☐ Pending investigation To the more a er death.

To the Funeral Director Af 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address reson who completed e of death (Mm 23a) (Type, Print) SNOW S. SNOW HEL, MD. 21863 BA 20 nth. Dav. Year) State JUN 2 5 2009 Registrar

1945		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
UNK	1	State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  2009 220
Physicia		Registrar  1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of Death
ical Exami		Wanda Jean Hackett June 23, 2009 Year 0533 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  Singli Hospital  Baltimore
Europol		Sinai Hospital  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  16 Under 1 Year   If Under 24Hrs.   8. Date of Birth(MM/DD/YYYY)   9. Birthplace (State or
Funeral Director		213-70-7956 1 M 2VF 5/ Yrs. Months Days Hours Min. June 17,1958 Foreign Country ry/and
		Usual Residence of Decedent
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or 28a	Director	7/20
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Marybard fealth and Menial Hygiene.  Tean 27 is marked other than "natural", or items 23a or 28a-f she trannatic event, the Medical Examiner must be notified at once.		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,
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1 2 1 d be fil ental P arked vent,	Be	RObert Hazel Hackett Betty Della Harris  19a. Informant's Name/Relationship (Type, Print)  19b. Mailling Address (Street and Number of Rural Route Number, City or Town, State, Zip Code)
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Dalliniore, permit. Pages 1 ar Department of Her Important: If ite		1 V Burial 2 Cremation 3 Removal from State crematory or other place) 4 Departion 5 Other Specify  Waugh Cenetery 7/2/09 Cambridge MD.
permit. P Departme Importan injury or	H	21. Signature of Funeral Service Licensee 22. Name and Address of Facility
		Janelle C. Henry 1510 Washington St. Cambridge, MD. 21613
Physician /Medical		23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as Serdiac or respiratory arrest, shock, or heart  Approximate Interval Between Onset and Death
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ਜ਼ਿਲ੍ਹ	edic	UNPENDED AMENDED  23c. If yes, outcome of pregnancy 23d. Date of delivery
LIVISION OF VICAL RECORDS, P.O. BOX 00/00, To the Hospital or Attending Physician: The law requires that the death certificate be exewithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician a completely filled in by the funeral director, page 2 should be detached for use as the burial.	sician/Medi	FEMALE: 23c. If yes, outcome of pregnancy 1
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ysician: The lysician: The lysician this certificate director, page		25. Was case referred to medical 26.Place of Death (Check only one)
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Jor Jing Phy After tl funeral	T:U	27. Manner of Death  28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 1 Natural 5 Pending FOUND:  28b. Time of Injury 28b. Time of Injury 28c. Injury at Work?  Subject assaulted  28d. Describe how injury occurred  Subject assaulted
or Attendate death. Director:	atic	2 Accident Investigation Jun 23, 2009 0427 hrs
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Hospital of 24 hours at Funeral D		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
To the Hospital within 24 hours To the Funeral completely filled	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
E N E S	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
1,		Potri Cu - Pollah m O.C.M.E. June 23, 2009
4		30. Name and address of person who completed cause of death (Item 23a)  Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
		Fathcia Arunica-Fullak MD. Assistant Medical Examinet 1111 Gilli Sueet, Dattilliote, MD 21201
	tate	

Wanda Jean Hackett

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #4a Per ME C893 7/10/09 JH
State of Mayland Department of Health and Mental Hygiene

1- For Amend # 6 per Fh g902 4/26/10 TT
Registrar
Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month Roxanne Henderson 9/8 Shelly /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 5227 Marlboro Pike **#30**2 Capital Height's P.G. 5. Social Security Number if Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex **Funeral** Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Months Days Min 4□M 2XF 33 Yrs Director 579-11-0727 5/14/1975 Wash.,DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any lijury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director XXYes 2 □ No Capital Height's P.G. MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20748 USA #302 5227 Marlboro Pike Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Completed by 1 ☐ Yes 2 → No Specify. SpecifyBlack 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wanda Jean Henderson Paul Jerome Montgomery ပို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3600 Ely Place SE.,#309,Wash.,DC.20019 Charles Lee Wilson/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【▼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/1/2009 Beltsville, MD Chesapeake 22. Name and Address of Facility 21. Signature of Funeral Service Licensee, 420 H St., NE B.K. Henry Funeral Home Wash.DC.20002 Henri 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician; The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 □Yes 2 No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☐No 24a. Was an autopsy performed? this certificate 1 □Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, i 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

# permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036

Physici /Media Examir

**Funeral** Director

Physician /Medical **Examiner** 

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

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1	For State Registrar	· (Final & Sindal)	- 1 and			, .a		rtificate d			2. Date of De	Reg. No	000	09	2 716	2091
	Norma		J	ean		Hawk	en	T.,			June 2	4, <sup>Da</sup>	2009	Year	1	1:18PM
ŀ	a. Facility Name <i>(It</i> Golden Li . Social Security No	ving C	ent	er		(In yrs. las	st birthday)		lericl	k nder 24 Hrs.	8. Date of Bir (Month, Da	F		rick	place (S	tate or Foreign
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ם ב	30 North		1	2. Was Dec	edent Ev	er in U.S.	13.	21	701	ic Origin? (Sp	ecify Yes or No	)- T	USA 14. Rac	e - Americ	can India	an,
	1 Never Marrie			Armed Fo 1XXYes If Yes, Gi Year or D	orces? 2 ∏ No ive		4	Was Decedent If Yes, specify 0 1 ☐ Yes 2 ☐	No Spe	exican, Puerto ecify:	Rican, etc.)		Specify		hite	2
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	Norman 19a. Informant's Na John Hawk							ing Address <i>(St</i> i	reet and N	lumber or Run				State, Zip	Code)	
-17-	20a. Method of Disp 1 ☐ Burial 2 ¶ 4 ☐ Donation	oosition Cremation	3 □ R	emoval from	State	1	ce of Dispenetery, cre	osition (Name of the control of the	f place)		Date 7/2009			City or To		nte
-	21. Signature of Fu		License	20.		_	2	22. Name and A	ddress of F	Facility Sta	auffer	Fune	erall	lome,	PA	)2
- varianci	shock, or hea immediate Cause ( disease or conditio resulting in death)  Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or that initiated events resulting in death) L	Final nditions, mediate rlying injury	b c	Due to	no (orașa m Ei		A nice of).	s C	TRO 1	rany	Anten	y Di	IS EAT	3 e T	Onset	ximate al Between and Death
	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months?	2		birth 2 nant at t	f pregnand Fetal of ime of dea	leath 3	☐ Ectopic pregr ☐ Other (specif						te of deliv	ery Day	Year
60 00	Part II. Other signif	icant conditi	ons con	tributing to d	leath but	not result	ing in the u	underlying cause	e given in I	Part I.			use cont	tribute to t		e of death?
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ב ב	25. Was case referrexaminer?  1 Yes 2 2 2  27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide	No	g gation not be	28a. Date (Mor	of Injury	Year) 2	28b. Time of Injury		Other: 4 Injury at Work? 1 □ Yes	Nursing Ho	th (Check only) ome 5 ☐ Res 28d. Describe 28f. Location City or To	how inju	ury occur	red		e Number,
100100	29a. Certifier (Check only one)	2☐ Medical	Exami	ner: On the		examination		ath occurred at t investigation, in				e, date ar	nd place,	and due t	to the ca	
	29b. Signature and	tiple of certifie	r	_				Do		7951		6 -	25	d (Month,	00 9	7
4	Name and addr	4. KAZ	LmI	MD.	8	147	Toll	Print)	AUE	. Fre	DERIC	{<,	MC	7	170	1
	31. Date filed (Mon.	JN 26	2009	De.	registrar	's Signat	A	ares								

Sta Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year JUL 2009 HOOPER ELOISE CAMILLE 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CHARL LATT CIVISTA MEDICAL CENTER LA If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, Social Security Number 6. Sex Months Days Hours Min. 1 □ M 2/CXF FEB.13,1925 WEST VIRGINIA 212-36-6724 84 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 □ Yes 2 💆 **K**o CHARLES WALDORF 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20603 U. S. A. 4233 MOCKINGBIRD CIRCLE 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐Yes 2 No 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ∐Yes 2XXXIo Specify: Specify: BLACK XXWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NURSING ASSISTANT JOHNS HOPKINS HOSP.

18. Mother's Name (First, Middle, Maiden Surname)

ELVIRA TWEEDY

4233 MOCKINGBIRD CIRCLE WALDORF, MD 20603

20c. Location - City or Town, State

BALTIMORE, MD

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9, 2009

with death v 76 21215-0036 Maryland outould be final than Mental Hv permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev 4 Baltimore, 9 0 0

**Physician** 

/Medical

Examiner

10a. State

17. Father's Name (First, Middle, Last)

4 □ Donation 5 □ Other (Specify)

20a. Method of Disposition

ARTHUR EDWARD KELLY 19a. Informant's Name/Relationship (Type. Print)

LINDA A. ALLEN/DAUGHTER

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

MD

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

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Examiner

Physician/Medical

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ir than "natural", or items 23a or 28a-f sho

marked other than "natural", or

**Physician** /Medical Examiner

requires that the death certificate be executed attending physician and for use as the burial-tran the detached signed by to be a detach cate has by page 2 s certificate I Physician: After this c

Box 68760

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Records.

of Vital

Division

Completed Be Certification: To Hospital or Attending s after deau.
ral Director: Aftr filled in by within 24 hours a Medical State Registrar

22. Name and Address of Facility RAYMOND FUNL.SERVICE, P.A. 21. Signature of Funeral Service Licensee our Bata Solo M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final afic Condiavasculos f thurselu disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0045203 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAVE. LAPLATA MD. 20646 SMITH MD. 5 GARRET STEPHEN 31. Date filed (Month, Day, Year) 32. Registra/s Signature **ORIGINAL** 

20b. Place of Disposition (Name of cemetery, crematory or other place)

LOUDON PARK CEM.

DHMH 17 Rev 1/2001

DK

09-05162

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Laurie Justison State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ June 30, 2009 Year 1400 hrs al Examiner Laurie Lee Justison 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Cecil Union Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min Months Days Hours Director 12/30/1976 222-72-0676 Maryland M 2X F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 X No Maryland Ceci1 North East Director 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number United States 934 Mechanics Valley Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 XNever Married Married Yes 2X No Yes 2 X No specify: White If Yes, Give Year Soecify: Divorced l other than "natural", the Medical Examiner ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. MD 21215-0036 Trave1 Dispatcher 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) event, Be Vincent T. Justison, Sr. Skinner <u>Deborah A.</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 934 Mechanics Valley Road North East, Maryland 2190 Deborah Graham / Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Baltimore, 20a. Method of Disposition crematory or other place) 2 X Cremation 3 Newark, Delaware Important: injury or otl Mayerdale Crematory Donation 5 Other Specify of Funeral Service Licenses 22. Name and Address of Facility Crouch Funeral Home Street, North East, Maryland 21901 South Main Approximate interval art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician Between Onset and failure. List only one cause on each line 'Medical Death Complications of narcotic intoxication ≟xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed Physician/Medical 23a,27,28a-f,perME, g893 7/13/09 TT XUNPENDED lending physician use as the burial The law requires that the death certificate be Box 68760 23d Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 ✓ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a, Was an autopsy prior to completion of cause of certificate has death? performed? ✓ Yes 2 1 V Yes 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be examiner? Hospital: 1 / Inpatient 2 Other 4 ER/Outpatient 3 Nursing Home 5 Residence 6 this 1 V Yes 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Certification: Natural 1 Yes 2 X No Pending hours after death. Fd 6/29/09 Fd 8:10 pm Director: 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State) **934 Mechanics Valley** 6 X Could not be Suicide (Specify) residence within 24 hours at To the Funeral D Rd. North East, MD Homicid 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 1, 2009 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD Assistant Medical Examiner 32. Registrar's Sig

State Registra

1 0 2009

			For State	State	of Marylan		rtment of			ental Hyg	jiene	0000	2000
			Registrar			Cer	tificate of	Death			eg. No.	2009	2209/
	Physici	an	Decedent's Name (First, Middle, La						2	<ol><li>Date of Dea Month</li></ol>	Day	Year	3. Time of Death
	/Medic			beth .			4. 00. 7			June	17	2009 County of Deat	4:30 <sup>P M</sup>
	Examin	er	4a. Facility Name (If not institution, give Woodside Cente		imber)		4b. City, Town, Silver					ntgome	
	Formul		5. Social Security Number 6. S		7. Age (In yrs.	last birthday)	If Under 1 Year		_	B. Date of Birth	1	9. Birtl	place (State or Foreign
	Funeral Director			□M 2 <b>X</b> F	95	Yrs.	Months Days	Hours	Min.	(Month, Day 1/29/19	, Year)	Co	DC
			Usual Residence of Decedent							_,_,,			
	irylan ihow	_	10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	8a-f s	Director	DC n/	a	Wa	shingt	7						
	vith th	Ö	10e. Street and Number	_			10f. Zip Code	. 1.0		1	-	en of What Co	
	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	erai	1366 Tewkesbury	_	NW cedent Ever in U	6 49 1	200		igin? (Snoo	ify Voc or No		ted Sta	
	ter de item	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed F		.5.	Was Decedent of f Yes, specify Cul	oan, Mexical	n, Puerto R	ican, etc.)	'	Black White	
38	urs af	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, G Year or I	ive		1□Yes 2 <b>½</b> No	Specify:				Specify: Ame	rican
21215-0036	2 hou	Completed	15. Decedent's E	ducation		16a. Deced	dent's Usual Occu	pation	et of working			d of Business/	
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pu	2 should be filed and Mental Hygi is marked other aumatic event, ti	Be	17. Father's Name (First, Middle, Last						,	First, Middle,	Maiden S	Surname)	
<u>₹</u>	should be fand Mental I s marked of numatic eve	ပ္	Frederick Tolson			10h Mailie	ng Address (Stree		a Gre		e City or	Town State 3	Tin Codo)
Maryland	d 2 st th and 7 is n traun		19a. Informant's Name/Relationship ( Patricia J. Duns		iohter		Tewkesbu						
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100	ages ent of tt: If it		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		i State		natory or other pl Memorial		5/24/2	2009	Suit	land,	MD.
Baltimore,	permit. Pages 1 and 2. Department of Health a Important: If Item 27 is any injury or other trauonce.		21. Signature of Funeral Survice Lice		1 112								ice, Inc.
ä	Dep Imp	; A	Dreta Ma	icis			400 Geor						
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that	caused the deal	th. Do not ent	er the mode of dy	ing, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between
	Physician	ė į	Immediate Cause (Final disease or condition			irator	y Failur	e					Onset and Death 3wks
1	/Medical		resulting in death)	Due to	(or as a consec	juence of):							
	Examiner		Sequentially list conditions,	D	ile Deb								4mos
	ed sit	Examiner	cause. Enter Underlying Cause (Disease or injury		(or as a consec		uo Hoart	Foi 1.	.**				2220
_	ecute and I-tran	хаш	that initiated events resulting in death) Last	C	(or as a consec		ve Heart	rallo	ure				2yrs
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687	ficate physis the	edical		▲d									
Box	The law requires that the death certific the has been signed by the attending page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		tcome pf pregn		7				2	3d. Date of del	ivery
<u> </u>	death e atte	icia	in the past 12 months? 1 ☐ Yes 2 🖾 No	4□Pre	birth 2 ☐ Feta nant at time of o		]Ectopic pregnan ] Other (spec <i>ify</i> )	cy ————				Month	Day Year
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ğ	w requires been signe should be	ed	Diverticulosis							1 D Y	/es 2 <b>1</b> 8	No 3□Pi	obably 4 Unknown
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<u> </u>	The page	5									rmed? 2 X No	death? 1 ☐ Yes	2□ No
Vita	i <b>cian:</b> Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Heapital					e of Death	(Check only o	ne)		
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Division or Vital Records,	ding F	ioi:	1 ■Natural 5 Pending	(Mo	nth, Day Year)	Injury	W	uryat ork? ]Yes 2□		8d. Describe h	iow injury	Occurred	
S	or Attending after death. Director: After in by the fune	lical	3 Suicide 6 Could not b	e 280 Plac	e of injury - At h	ome, farm, str	eet, factory, office			Bf. Location (S	Street and	d Number or R	ural Route Number,
<u>S</u>	i <b>Pit</b> e	Certification:	4 ☐ Homicide determined		ding, etc. (Speci					City or Tow			
	To the Hospital within 24 hours a To the Funeral I completely filled		29a. Certifier 1X Certifying P										
	he He in 24 he Fi plete	Medical	(Check only 2 ☐ Medical Exa		nner stated.	ation and/or in	vestigation, in my	ориноп, ае	auri occurre	at the time,	date and	place, and du	e to the cause(s)
	To the To the complet	Σ	29b. Signature and title of certifier	0 04	^			nse number	_			e signed (Moni	
	10		2 le augh	Belton	m-1).		M	D22586	6	-	6	5/18/20	U9
			30. Name and address of person who	completed car	use of death (Ite		·	NT 7	- 00	, ,,		5.0	20000
	0		E. DeVaughn Belt 31. Date filed (Month, Day, Year)		Registrar's Sign	-	ra Road,	NW S1	ce.334	+, wash	ııngt	on, DC	20009
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DHMH 17 Rev 1/2001

			1 - For State Registrer	State of Ma			tment ificate			Mental H	Hygiene Reg. No.	009	22098
	Physici	an	Decedent's Name (First, Middle, Las							2. Date of Month	Dav	2009	3. Time of Death 6:30 A M
	/Medic Examin	al	Ruth Naomi Kovato  4a. Facility Name (If not institution, give Caroline Nursing	street and number)			4b. City, T		Location of Dea	June	4c. Cc	ounty of Death	
	Funeral Director		5. Social Security Number 6. Se		(In yrs. last bir	thday)	If Under		If Under 24 Hr Hours Mir	/Adonth	Birth Day, Year) 18, 192	Cau	place (State or Foreign ntry) 'land
	B Maryland a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Caroline		10c. City, Town	m or Loca	ation						10d. Inside City Limits 1 ∰Yes 2 ☐ No
	or 28	Directo	10e. Street and Number				10f. Zip				10g. Citize	n of What Cou USA	intry?
9	after death v or Items 23s	Funeral	520 Kerr Avenue  11. Marital Status  1 □ Never Married 2 □ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give		i			spanic Origin? n, Mexican, Pue Specify:	(Specify Yes or ento Rican, etc.)		Race - Ameri Black, White	, etc.
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel', or Items 23a or 28a-f show amy injury or other treumatic event, Ire Medical Examinant to Indifficult and Once.	Completed by	3 X Widowed 4 □ Divorced  15. Decedent's Ec (Specify only highest gra  Elementary/Secondary (0-12)	Year or Dates:		Decede						of Business/Ir	ndustry
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land	uld be filk hental Hy rked oth	To Be	17. Father's Name (First, Middle, Last) Thomas Charles Kn	eavel						ine Noh	a.	<i>im</i> ame)	
lary	2 shou and N is man	_	19a. Informant's Name/Relationship (								ımber, City or T		ip Code)
ore, N	ges 1 and of Health If item 27 or other tr		James Kovatch/Son  20a. Method of Disposition  1 □ Burial 2 🛣 Cremation 3 □		20b. Place o cemete	of Dispos ery, crem	ition (Nam atory or ot	ne of ther plac	e)   (10	Date		tion - City or T	
Baltimore,	ermit. Pag Department mportent: Iny injury o		* 4 □ Donation 5 □ Other (Specify 21. Signature of Puneral Service) ce	$\sim$	Cremator	-				4/2009	Delman O. Box w Marke	207 <sub>MD</sub>	
	20380	$\mathcal{L}$	23a. Part 1. Enter the disease, or commock, or heart failure. List only	olications that caused	the death. Do							L, MD	Approximate Interval Between
	Physician /Medical bubble science physician and bubble science steep the physician street bubble science of the physician	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a b. Due to (or as a c.		of):						- 1	Onset and Death
P.O. Box 68760,	The law requires that the death certificate be ate has been signed by the attending physicit agge 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death		Ectopic pr Other (sp					d. Date of deli Month	Day Year
	w requires that been signed should be del	by	Part II. Other significant conditions of					ause giv	en in Part I.		23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown		
of Vital Records,	The law requisate has been page 2 should	Completed								-	Was an autopsy performed?	24b. Were au prior to d death? 1 ☐ Yes	topsy findings available completion of cause of 2 \( \sum \text{No} \)
Vita	Physicien: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Oth	/	Death (Check o			
on of	ys dis	tlon: To	1 ☐ Yes 2 ☑ No  27. Manner of Death  1 ☑ Natural 5 ☐ Pending investigation	28a. Date of Injui (Month, Day	nt 2 ER/O ry 28b. y Year)	Time of Injury		8c. Injur Wor	Nursing		Residence 6 ribe how injury		city)
Division	I or Attending Ph after death. Director: After th I in by the funeral	Certification:	2 Accident 3 Suicide 4 Homicide			farm, stre	et, factory		-		ion (Street and r Town, State)	Number or Ru	ıral Route Number,
	To the Hospitel or Att within 24 hours after d To the Funerel Direct completely filled in by	edical C	29a. Certifier 1 Certifying Pt (Check only one)	ysicien: To the best on niner: On the basis of and manner sta	f examination at	ge, death nd/or inv	occurred estigation	at the tir , in my o	ne, date and pla pinion, death or	ace, and due to	o the cause(s) a ime, date and p	nd manner as place, and due	stated. to the cause(s)
)	To th To the compl	Me	29b. Signature and title of certifier		-W	ai			e number	55	. 1	signed (Month	
			30. Name and address of person who Melinda But	completed cause of d	leath (Item 23a)	) (Type, i	Print)						
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	22 Pagistr	ar's Signature								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) рМ **Physician** 19 2009 6:28 June <u>Jean Ann Melkin</u> /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, **Funeral** Year) Hours Min 1 □ M 2 🗓 F Director 12/04/1923 New York 069-16-6971 85 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Medical Examinal must be notified at 1 X Yes 2 ☐ No Director Rockville Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20852 1801 East Jefferson Street #531 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 🛣 No Specify. Specify. þ 3 ☑ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Residential Const General Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٩ Philip Thur Celia "Unknown" 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11802 Charen Lane Potomac, MD 20854 Matthew Melkin / Son Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King David Mem. Gdns June 23, 09 Falls Church, VA 21. Signature Fundal Service Licensee 22. Name and Address of Facility Danzansky-Goldberg Mem. Chapels 1170 Rockville Pike Rockville, Maryland 20852 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Atherosclerotic heart disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enler Unidenlying Cause (Disease or injury that initiated events are utilized to the cause of t Examiner Due to (or as a consequence of) law requires that the death certificate be executed and burial-trar resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical the attending ph nse : IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No 4 Pregnant at time of death 5 Other (specify) P.0. detached 9 I Unknown 23e. Did tobacco use contribute to the cause of death? signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 □ Yes 2 DXNo Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \( \text{Nursing Home} \) 1 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) 1 ☐ Yes 2x No 1 Inpatient 2 X ER/Outpatient 3 ☐ DOA Medical Certification: To this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Hospital or Attending 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie June 20, 2009 D39456 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20815 Lila McConnell, MD, 5530 Wisconsin Ave, Suite 1400, Chevy Chase, Maryland 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

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Registrar

**JUN 25** 

State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician**  $p^{M}$ 16, 2009 7:35 Julio Cesar Montano Jr. June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Days Months 1 🛣 M 2 🗆 F Maryland 0 June 16, 2009 Director 0 0 0 None Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Rockville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any lighty or other traumatic event, the Medical Exempter 2008. Funeral 13217 Ardennes Avenue 20851 Untied States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 √ Yes 2 No Specify ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 0 None None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Montano Ana Aguayo Julio ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13217 Ardennes Avenue; Rockville, MD 20851 <u>Julio Montano / Father</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Ft. Lincoln Crematory 6/23/2009 Brentwood, MD 21. Signature of Puneral Service Licensee 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Entry the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or part failure distance on each line. Approximate Interval Between Onset and Death Immediate /au/ e (Final disease or c ition resulting in death) **Physician** 1 day Preterm Labor /Medical Due to (or as a consequence of): Examiner 1 week Bleeding Placenta Previa Sequentially list conditions, if any leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Extreme Prematurity attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) 1 □Yes 2 XNo certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>6</u> 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ☑ No ours after death.

eral Director; After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 ⊠ No Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 → Natural 2 → Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier within 24 ho

To the Fune

completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 lu 06-17-2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12201 Plum Orchard Drive; Silver Spring, MD 20904 Elizabeth S. Musoke, M.D. 3 Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 25 Registrar

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**ORIGINAL** 

			For State Registrar	tate of Maryland		irtment of He tificate of D		lental Hygie Reg.	d3	22101	
			Negistrar  1. Decedent's Name (First, Middle, Last)					2. Date of Death	C U U 3	3. Time of Death	
	Physicia /Medic			MEREDITH DON	ALD M				2009 4. 2009	12:53 P M	
	Examin	er	4a. Facility Name (If not institution, give stre Kline Hospice House			4b. City, Town, or L			Frederic		
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. las	st birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreign	
	Director			<sup>2□ F</sup> 78	Yrs.	- Jayo		May 6, 19	931   Mary	vland	
	/land		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Loc	cation				10d. Inside City Limits	
	a-fsh	ctor	Maryland Frederick	Thur	mont					Yes 2 No	
	vith the	Director	10e. Street and Number			10f. Zip Code 217	QQ	10g.	Citizen of What Cou		
	ns 23a	Funeral	35 Water Street  11. Marital Status 12.	Was Decedent Ever in U.S.	13. \	Was Decedent of His f Yes, specify Cubar		ecify Yes or No-	14. Race - Amer	ican Indian,	
36	within 72 hours after death with the Maryland iene. than "natural", or items 23a or 28a-f show the Medical Examinat must be Institlied at	ğ	1 □ Never Married 2 □ Married  3 🛣 Widowed 4 □ Divorced	Armed Forces?  1X Yes 2 No Kor  If Yes, Give  Year or Dates: Vietn	ea	fYes, specify Cubar I□Yes 2 <b>X</b> No	Specify:	Rican, etc.)	Black, White	,etc. nite	
21215-0036	72 hou natura lical E	Completed	15. Decedent's Educat (Specify only highest grade of	on	16a. Deced	dent's Usual Occupa kind of work done du	tion uring most of worki		. Kind of Business/li	ndustry	
121	vithin 7	mple	Elementary/Secondary (0-12)	College (1-4or 5+)    Tife. DO NOT use retired)					U.S.∶Goveı	nment	
d 2	filed v Hygie other i	e Co	17. Father's Name (First, Middle, Last)					(First, Middle, Mai			
ılan	uld be Mental irked c	To Be	Jesse Herman Moxle	7			Mary Con				
Maryland	nd 2 sho alth and I 27 is ma r trauma		19a. Informant's Name/Relationship (Type: Susan M. Templeton		19b. Mailir 13179	ng Address <i>(Street a</i> Ladybank	nd Number or Run Lane, He	al Route Number, C erndon, V	ity or Town, State, Z irginia 20	ip Code) 0171 	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinating in 1816 of 31 once.		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Ren 4 ☐ Donation 5 ☐ Other (Specify)			sition (Name of natory or other place g Cremato	) !		ithsburg,		
Balt	permit. Departr Imports any Inji		21. Signature of Funeral Service Licens	releas of	Ř 6				RAL HOMES ONT, MD 2	1788 <sup>A</sup> .	
A store	Physician /Medical	e i	23a. Part / Enter the disease or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ions that caused the death, cause on each line.  Due to (or as a conscipe	Do not ent	er the mode of dying 20/AL Hillu	s, such as cardiac	or respiratory arrest	,	Approximate Interval Between Onset and Death	
1	Examiner		Securitizity list conditions b. if any, leading to immediate	met	asta	itic lu	ny Co	ncer		would.	
	uted I Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a conseque	ence or):		)				
Ć,	cate be executed physician and the burial-transit	Еха	that initiated events c resulting in death) Last	Due to (or as a conseque	ence of):						
8760,	ate be hysicia the bu	dical	d								
O. Box 6	death certifi e attending l d for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	. If yes, outcome of pregnan 1  □ Live birth 2  □ Fetal o 4  □ Pregnant at time of de 9  □ Unknown	death 3[	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of del Month	ivery Day Year	
σ.	law requires that the de las been signed by the a 2 should be detached to	by	Part II. Other significant conditions contri	buting to death but not result	ting in the u	nderlying cause give	on in Part I.		cco use contribute to	the cause of death?	
Vital Records,	The ate h	Completed						24a. Was an autopsy performe 1 □ Yes 2 •	prior to o	topsy findings available completion of cause of 2 No	
V:It	Physiclan: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?  1 Yes 2 No	spital: 1 ☐ Inpatient 2 ☐ E	D/Outpatio	othe	ar:	th <i>(Check only one)</i> ome 5 ☐ Resident	ce 6 ⊉Óther (Spe	city Herrore	
o	ng Tel	on: To	27. Mann of Death 1 atural 5 ☐ Pending		28b. Time o Injury	f 28c. Injury Work	/ at ?	28d. Describe how		City)	
Division	or Atten after deat Director: in by the	Certification: To	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, sti		Yes 2 □No	28f. Location (Stree City or Town, S	et and Number or Ru State)	ural Route Number,	
	Hospital 24 hours a Funeral I etely filled	Medical C	29a. Certifier 1 Certifying Physic Check only one 2 Medical Examine	cian: To the best of my know r: On the basis of examinati and manner stated.	rledge, deat ion and/or ir	th occurred at the tin nvestigation, in my o	ne, date and place pinion, death occu	, and due to the cau rred at the time, date	use(s) and manner a e and place, and due	s stated. to the cause(s)	
	To the within To the compl	Me	29b. Signature and title of certifier	AZIMO	)	JU 4	416L	290	I. Date signed (Mont	h, Day, Year)	
نا	et l		30. Name and a ress of person who com	nas Johns	23a) (Type	Print) Fr	ednich	217	02		
	Sta Regist		31. Date filed (Month, Day, Year) 26	32. Registrat's Signatu	J.	parket.					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Indep Indep Indep I tem 23a per phys. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. Not... 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** JULY 1,2009 4:30A JAMES ALVIN MARSHALL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CHARLES 4450 MIDDLETOWN ROAD POMFRET If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
1 (Month Day Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days NEW Cou Months Hours Min. YORK 82 049-20-4908 Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Eventing to use to motified at POMFRET 1 Yes 2 No MD. CHARLES Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20675 U.S.A. 4450 MIDDLETOWN ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Mayes 2 ☐ If Yes, Give Year or Dates: 1 Never Married Married 2 🗌 No ARMY Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: Specify: BLACK Completed by 3 Widowed 4 Divorced WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) PHARMACIST SELF EMPLOED 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOSEPH MARSHALL AMANDA DYSON ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health as Important: If Item 27 is any injury or other trauonce. 4450 MIDDLETOWN RD. POMFRET, MD. 20675 CORA S.MARSHALL-SPOUSE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ACremation 3 Removal from State TROPOLITAN CREMATORY 7-2-09 ALEX., VA. MQ0479 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MD. 20646 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of):

Chronic Renal Disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Deat 28c. Injury at Work? 28d. Describe how injury occurred 12 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours a er dealh.

To the Funeral Director A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Comparison of the death occurred at the time, date and place, and due to the cause(s) and due to t Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 20646 Plata

State Registrar Year)

JUL

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

DX

32. Registrar's Signature

		1	State of Maryland / Dep   = State AMEND#25+28a-fperME,6/30/09,BW,MCC Ce	artment of Health and N <i>rtificate of Death</i>	lental Hygier ه	ne 2009	22103
	100		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Betty Frances Pozarek			2009	5:37 p M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death Prince Frederick		4c. County of Deatl  Calvert	
4 10	724.23.74		Calvert Memorial Hospital  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)		8 Date of Birth	9. Birtl	hplace (State or Foreign
A,	Funeral Director		213-46-9509 1□M 2 ☐ 82 Yrs.	Months Days Hours Min.	July 20,	1926 Was	hington, DC
	156		Usual Residence of Decedent				10d. Inside City Limits
	arylan show dat	<u>_</u>	10a. State 10b. County 10c. City, Town or L				1 ☐ Yes 2 🗗 No
	he Ma 28a-f	Directo	Maryland Montgomery Sil  10e. Street and Number	ver Spring 10f. Zip Code	10g.	Citizen of What Co	untry?
	with a or a		1309 Mimosa Lane	20904		USA	
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame Black, White	
စ္	after or ite		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💆 No If Yes, Give	1 ☐ Yes 2 No Specify:	Tributi, otoly	Coorie	ite
003	ural",	d by	3⊠ Widowed 4 □ Divorced Year or Dates:	edent's Usual Occupation	16h	Kind of Business/	
<u>7</u>	n 72 t "nat edica	lete	(Specify only highest grade completed) (Giv	e kind of work done during most of work DO NOT use retired)	ing	. Tanto of Baomood	, , , , , , , , , , , , , , , , , , ,
7	withi	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker		Own	Home
٦	e filec al Hyg I othel vent,	Be C	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid		
<u>ylaı</u>	2 should be f n and Mental H is marked of raumatic eve	10	Frederick Benjamin Hazel		O'Connel:		7.0.4
Baltimore, Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylar of Health and Mental Hygiene 1 hours attent 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship ( <i>Type. Print</i> )  Mary J. Parker/Daughter  19b. Mai  28	ing Address (Street and Number or Ru 35 Shanandale Driv	rai Houte Number, Ci re, Silver	Spring,	MD 20904
a)	1 and 2 Health tem 27 i		20a. Method of Disposition 20b. Place of Dis			. Location - City or	Town, State
JOE L	Pages ent of nt: If it			Heaven Cemetery	ne 26 2009   Si:	lver Snri	ng, Maryland
≡	permit. Pages 1 am Department of Heal Important: If item 2 any Injury or other once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Francis J. Collins	Funeral 1	Home Inc.	200
<u>m</u>	De la la la la la la la la la la la la la		Acon & Contra	500 University Blv	d. W., Si	lver Spri	ng, MD 20901
			23a. Part 1. Emer the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.		or respiratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	uphixiahin			10 minules
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. CNOWLY Condition Due to (or as a consequence of):  Sequentially list conditions	Tucturetre.			10 minuls
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury	cy s por top			
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.			<u> </u>	
Ö,	ate be executed hysician and the burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):				
8760,	cate be executed physician and the burial-transit	dical	d				
ဖ	death certific e attending p d for use as '	Physician/Med	IF FEMALE: 23c. If yes, outcome pf pregnancy			23d. Date of de	livery
Box	w requires that the death certific been signed by the attending p should be detached for use as	cian	in the past 12 months?	□Ectopic pregnancy □ Other (specify)		Month	Day Year
P. 0.	t the d by the ached	hysi	1 ☐ Yes 2 ♠ No 9 ☐ Unknown				
	The law requires that the ate has been signed by thoage 2 should be detache		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.			o the cause of death?
ord	equire en sig	ted	Climentra		1 Tes	2 <b>⊠</b> No 3□P	robably 4 □Unknown
ecc	g 82 C	Completed by	pronchites		24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
E H	The		morbid obesity		1  Yes 2 2	No 1 ☐ Yes	
₹   	Physician: r this certificaral director,	Be c	25. Was case referred to medical examiner? 1 XYes 2 XH00 Hospital: 1 XInpatient 2 ☐ ER/Outpat	Othor	<u>ith <i>(Check only one)</i></u> lome 5 ☐ Residenc	e 6 DOther (So	acifu)
Division or Vital Records,	y Phy er this eral di	<u>ان</u>	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe how	injury occurred	
ion	Attending r death. ector: After by the fune	ation	1 □ Natural 5 □ Pending (Month, Day Year) Injury  AC Accident investigation 6-21-09 170	4 17 17 17 18 17 18 18	eubject d	hoked on	food
i Nis	r Atte er dea irecto	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	Calvert	et and Number or F State) Iemorial I	Rural Route Number,
	oital or urs afte eral Dir		Hospital  29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	ath accurred at the time, date and place	Prince Fr	ederick,	Maryland
	the Hospital hin 24 hours a the Funeral I	edical	29a, Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, de (Check only one)  1 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occu	urred at the time, date	e and place, and du	ue to the cause(s)
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Mec	DOL Simply wound the Att additional I	29c. License number	29d	. Date signed (Mon	oth, Day, Year)
)	7			D46419		6/20/	105
	(		30. Name and dorress of person who completed cause of death (Item 23a) (Type Chair LL LL+Ch4) (100	e, Print) OHOSPITEURO	Prince Fre	edenck,	M20078
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 22. Registrar's Signature 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	D46419 DHOSPITEUL ROL			

			For State Registrar	State of Maryla	•	artment of H		d Mental Hy	ygiene Reg. No. 2	009	2210	
	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of D Month	-		3. Time of Death	
	/Medi Examir	cal	Nancy Anne F  4a. Facility Name (If not institution, give 5900 Whaleboat Dri	eirce street and number) ve		4b. City, Town, or Clarksvi		June		y of Death	9:05P. N	7
	Funeral Director		5. Social Security Number 6. Security Number 11	7	s. last birthday) 73 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	s. Date of B	irth 25,1935	9. Birthpla Texas	ice (State or Foreigy)	gr
	Maryland -f show	ţō	Usual Residence of Decedent  10a. State 10b. County  Maryland Howard	10c. C	City, Town or Local Larksvi	eation Lle				100	d. Inside City Limit	
	h with the 23a or 28a st be noti	al Direc	10e. Street and Number 5900 Whaleboat Dr	rive		10f. Zip Code 21029			10g. Citizen of United	What Country		_
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, The Modifiel Evernina must be notified at once.	Completed by Funeral Director	11. Marital Status  1 ☐ Never Married 2 X Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ You If Yes, Give Year or Dates:		Vas Decedent of H fYes, specify Cuba □Yes 2XNo	ispanic Origin? in, Mexican, Pu Specify:	(Specify Yes or N erto Rican, etc.)	lo- 14. Ra Bla Speci	ace - Americar ack, White, etc ify: W		
21215-0036	I within 72 he giene. r than "natu rhe Medical	ompleted	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life. L	lent's Usual Occup: kind of work done o OO NOT use retired O <b>cher</b>	ation during most of v l)	vorking	16b. Kind of E		stry	
Baltimore, Maryland	should be filed wand Mental Hygies marked other tumatic event, In	To Be C	17. Father's Name (First, Middle, Last) Frank Kratovil				18. Mother's N Harriet	lame (First, Middle Young	e, Maiden Surna	me)		
, Mar	and 2 sho ealth and n 27 is ma	L S	19a. Informant's Name/Relationship (7 James W. Peirce -H	lusband	5900	g Address (Street a Whaleboa	t Drive		ville, M	ərylənd	d 21029	
timore	permit. Pages 1 Department of H Important: If iter any Injury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		etropol	sition (Name of natory or other plac itan Crem	atory 6			dria, V	Virginia	
	permit Depar Impor any In		21. Signature of Funeral Service Licen	Honos.	Ď₀ 44	Name and Address 100 V. 400 Powde	Borgwar r Mill	dt Funer Road Bel	al Home tsville			<u>C</u>
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the deane cause on each line.  Metastati  Due to (or as a conse	c Ovari			liac or respiratory	arrest,	20	Approximate nterval Between Dnset and Death Years	
,		dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect.  Due to (or as a consect.								_
.O. Box 68	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 24 No 9 □ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pregnancy	/			ate of delivery	y Day Year	_
rds, P.	quires that n signed b	þ	Part II. Other significant conditions or	ntributing to death but not re	sulting in the ur	derlying cause give	en in Part I.		tobacco use cor		cause of death?	'n
of Vital Records,	lan; The law requir rtificate has been s tor, page 2 should	Completed						24a. Wa auto peri 1 □ Yes	opsy formed?	prior to comp death?	sy findings available pletion of cause of	le
Vita	siclan; certific rector,	Be (	25. Was case referred to medical examiner?	Inne Ant		lou		eath (Check only				_
of	Physic ruthis erral dir	2	1 Yes 2 XNo 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 [ 28a. Date of Injury	ER/Outpatien		4 LI Nursing	Home 5 Res	sidence 6 🗆 O			_
/ision	or Attending after death. I Director: After d in by the funer	Certification:	1/≦ Natural 5	(Month, Day, Year)  28e. Place of Injury - At building, etc. (Spec	Injury home, farm, stre		y at ?? Yes 2 □ No	28f. Location	(Street and Num		- Route Number,	
Ö	spita ours eral fille		29a. Certifier 1 X Certifying Phy	rsician: To the best of my kr	nowledge, death	occurred at the tir	ne, date and pl	ace, and due to th	own, State) e cause(s) and re-	manner as sta	ited.	_
	To the Hos within 24 h To the Fun completely	Medical	one)  29b. Signature and title of certifier	and manner stated.	Tation and or in	29c. License		ocurred at the time				_
	12		Druhy Lo	All mis		D385			June 2.			
			30. Name and address of person who con Nicholas W. Koutre				uvent T	olawa Col	umbio	Maw.1 ລາ	nd 21044	
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Sign		LLLE FOL	avelir L	Kwy, COI	ا و ۱۵۰۰	потуто	.14 21044	-

State Registrar

JUN 24 2009

DHMH 17 Rev 1/2001

09-05153 Jennifer Lynn Peddicord

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 22105

	,		- For State Certificate of L		Reg.	No.					
	Physicia	_	Registrar 1. Decedent's Name (First, Middle,Last)		Date of Death     Month Da	av Year	3. Time of Death				
F	ા Examir		Jennifer Lynn Peddicord		June 30, 200	9	1008 hrs				
			4a. Facility Name (if not institution, give street and number)  4b	. City, Town, or Location of Death		4c. County of Death					
			10870 Crain Highway Apartment 2	Faulkner		Charles					
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs.  Months Days Hours Min.	-	Co	thplace (State or Foreign untry)				
	Director	Ì	214-19-6167 <sub>1 M 2</sub> X <sub>F</sub> 34 Yrs.	.975 Was	hington D.C.						
		ŀ	Living Parishan of December 1								
	any	ı	10a. State 10b. County 10c. City, Town or Locatio	n			10d. Inside City Limits				
	<u>*</u>	_	MD Charles LaPlata				1 Yes 2 X No				
	Maryland 28a-f show d at once.	왕	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	intry?				
	th the Maryland 23a or 28a-f sho notified at once.	Director	8680 Cooksey Road	20646	Ur	nited Stat	es				
3	vith t s 23a e not	The proof of the p									
	item item	Funeral	1 X Never Married 2 Married Armed Forces? If Ye	s, specify Cuban, Mexican, Puerto	Ricari, etc.)	White, etc.	_				
	fler d		3 Widowed 4 Divorced If Yes, Give Year 1	Yes 2 X No specify:			nite				
	ours a	d b	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's during mo	s Usual Occupation (Give kind of w st of working life. DO NOT use retir	vork done 1 red)	6b. Kind of Business	/Industry				
	6 172 hou an "nat ical Exa	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+)				Tama				
	5-0036 led within 7 Hygiene. other than the Medica	g		ric Nursing Aid	<u> </u>	Nursing H	Tome				
	5-003( led within Hygiene. I other tha the Medic	O	17. Father's Name (First, Middle, Last)	18.Mother's Name							
	2121 hould be fill and Mental F is marked tic event,	å	Patrick Michael Peddicord	Address (Street and Number or F	atherine		te. Zin Code)				
	LD 21215-003 should be filed within and Mental Hygiene. T is marked other that it antic event, the Mental the	2	Tool Mileting Health Street	Box 1742, LaP1:							
	ore, MD s 1 and 2 sho of Health and If item 27 is			tion (Name of cemetery,		20c. Location - City of	or Town, State				
	IOCE, MD 2 ges I and 2 shou at of Health and N t: If item 27 is n other traumatic		1 Duriet 2 ViCrometion 3 Removal from State crematory or oth	er place)	2 /2000	M1 0440	11-11 MD				
	Page nent ant: or oth	- 8	4 Donation 5 Other Specify:	thois Crematory 7/		Charlotte					
	Baltimore, ME permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum	ш	21. Signature of Funday Colvins Liberioco			uneral Ho					
	<b>m</b> 8 9 7 7 1		3t. 9. 5itt	P. O. Box 600,	Lusby Mi	aryland 20	Approximate Interval				
	Physician		23a. Part I. Enler the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line. <b>Mixed drug (meth</b>	adone, hydrocodo	ne, traza	adone &	Between Onset and Death				
	Medical xaminer	W 9	Immediate Cause (Final disease a. alprazolam) intoxicat	ion							
			or condition resulting in death)  Due to (or as a consequence of):								
		er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
		nin	cause. Enter Underlying Cause (Disease or injury that initiated								
	l iit	Examin	events resulting in death) Last Due to (or as a consequence of):								
	760, icate be executed physician and the burial - transit		d. 23a, 27, 28a-f at	erME, g893 7/23	/09 TT						
	be exician	Medical	XUNPENDED AMENDED Z3a, Z7, Z6a-1,			Tool Division					
	760, icate by physic the burn		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy	tal death 3 Ectopic pregn	ancv	23d. Date of deliv Month	ery Day Year				
	68 certif nding se as	ian	past 12 months?	her (Specify)	,		·				
	Box 687 he death certific the attending p	Physician	1 Yes 2 No 9 V Unknown 9 Unknown	101 (9, 44.7)							
	that the or the detached		Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.			to the cause of death?				
	ords, P.O. w requires that the secons signed by should be detacted.	<u> 5</u>			1 Yes		robably 4 V Unknown				
	of Vital Records, ng Physician: The law requir Aher this certificate has been s meral director, page 2 should I	etec			24a. Was a autops		autopsy findings available to completion of cause of				
	law r has b	du			perfor	med? death	1?				
	tal Recian: The certificate ector, page	S	O Since (Charle of Nation)								
	tal cian: certi	a	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatien	Other:		Residence 6 V O	ther: Scene				
	FVi Physi er this ral di	유	1 V Yes 2 No Imparent 2 Eroscipeum  27. Manner of Death 28a. Date of Injury 28b. Time of			now injury occurred					
25. Was case referred to medical examiner?  1  Yes 2 No  25. Was case referred to medical examiner?  1  Yes 2 No  26. Place of Death (Check only one)  26. Place of Death (Check only one)  26. Place of Death (Check only one)  27. Manner of Death  1  Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?  28d. Describe how injury occurred  28d. Describe how injury occurred											
	Sior Attend r death ector: by the	[at	2 Accident Investigation Rd 0/30/09 Rd 100		28f. Location (S	Street and Number or	Rural Route Number, City				
	Division tal or Attendiars after death.	Certification:	Suicide Could not be determined (Specify) residence		or Town, S	tate)10870 C FAulkner,	rain Hwy. MD				
	in ou		4 Homicide	rred at the time, date and place, ar	nd due to the caus	e(s) and manner as :	stated.				
	To the Hos within 24 h To the Fur	ica	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation	ation, in my opinion, death occurred	at the time, date	and place, and due t	o the cause(s)				
	To the within 2 To the complete	led	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)								
		29b. Signature and title of certifier  O.C.M.E.  July 1, 2009									
			pour 7	ľ							
			30. Name and address of person who completed cause of death (Item 23a)  Russell Alexander MD. Assistant Medical Examiner 11	1 Penn Street, Baltimore, I	MD 21201						
			22 Paietrar's Signature		OCME						
		State	31. Date filed (Month) Day, Year) 2009 22. Registrar's Signature	ake							

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	State of Ma	aryland	•	artment of F rtificate of I	lealth and N Death		jiene eg.No. 2000	0 00100
			Registrar  1. Decedent's Name (First, Middle, L	ast)			inouto or i		2. Date of Deat	th	3. Time of Death
П	Physicia		ELEANOR JEANET'	TE PHELPS	PHELPS					Day Yea 2009	B:30A M
	/Medic Examin		4a. Facility Name (If not institution, g	ve street and number)			4b. City, Town, or	r Location of Death		4c. County of De	eath
			FREDERICK MEMOR				FREDERI		T =	FREDER	
ı	Funeral Director			Sex 7.Ag	e (In yrs. la 92	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Mopth, Day) March 4,	1917 Ma	Birthplace (State or Foreign Country) Lry Land
	w w		Usual Residence of Decedent  10a, State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
	Maryla f sho	jo	Maryland Freder	ick		ederic					1 □ Yes 2 □ No
	r 28a-	irec	10e. Street and Number	.OR		CGCLIO	10f. Zip Code		1	0g. Citizen of What	
	h with	a D	4840 Shookstown	Road			217	702		U.S.A.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventing must be notified at once.	Completed by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1  Yes 2  If Yes, Give Year or Dates:			Was Decedent of H fYes, specify Cuba 1 □Yes XX No	lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	Black, Wi	merican Indian, hite, etc. hite
21215-0036	in 72 hou n "natura solicale	pleted	15. Decedent's I (Specify only highest g	Education rade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work	ring	16b. Kind of Busine	
212	y withi	mo	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Но	memaker			Own H	[ome
pu	e filec al Hyi d othe vent,	Bec	17. Father's Name (First, Middle, Las						,	Maiden Surname)	
yla	ould b Ment arkec	2	Raymond Loui		:.					Hildebran	
, Mar	and 2 sh salth and 1.27 is m er traum		19a. Informant's Name/Relationship Mrs. janice E. Kr		hter					r, City or Town, State	
Baltimore, Maryland	Pages 1 a nent of Hea ant: If item ary or othe		20a. Method of Disposition 1		Roce	lace of Dispo emetery, crer CKy Sp	sition (Name of matory or other place PINGS Cen	netery Ju	1y 10, 2	20c. Location - City 2009 Fred	orTown, State erick, MD
Balt	permit Depart Import any inj		21. Signature of Funeral Service Lic		10025	$\begin{bmatrix} 22 \\ 1 \end{bmatrix}$	Reeneydra 06 East (	ind Basfo Church St	rd PA Fu ., Frede	meral Homerick, MD	e 21701
			23a. Part 1. Enter the disease, or co shock, or heart failure. List only	nplication that caused y one cause on each li	d the death ne.	n. Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory are	rest,	Approximate Interval Between Onset and Death
Lang.	Physician		Immediate Cause (Final disease or condition resulting in death)	a. SEP.							Onset and Death
The same	/Medical Examiner		resulting in death)	Due to (or as			FAILU	DE			
	MET	ē	Sequentially list conditions, if any, reading to maneutate cause. Enter Underlying Cause (Disease or injury	b. Oue to (or as			1111111	re			
	cuted Id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c								
,0928	icate be executed physician and the burial-transit	al Ex	resulting in death) Last	Due to (or as	a consequ	uence of):					
387		edical		d							
P.O. Box	Physician: The law requires that the death certific this certificate has been signed by the attending I rail director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	I death 3	⊒ £ctopic pregnand ☑ Other <i>(specify)</i> _	cy		23d. Date of Month	delivery Day Year
	ires that t signed by d be detad	by	Part II. Other significant conditions	contributing to death b	out not resu	ulting in the u	nderlying cause giv	en in Part I.			e to the cause of death?
COL	w requ	letec							24a. Was a	an 24b. Were	autopsy findings available
of Vital Records,	The law ate has page 2 s	Completed							autop perfor 1 □ Yes	med? death	
/ita	ding Physician: The h. After this certificate hit funeral director, page	Be (	25. Was case referred to medical examiner?	Line site is				26. Place of Dea	th (Check only or	ne)	
of	Physi this c	٠ <u>.</u> ۲	1 ☐ Yes 2 ☐ No  27. Manner of Death	Hospital: 1 Inpati		ER/Outpatier	IL 3 LI DOA			ence 6 Other (5	Specify)
on	ding J. After fune	tion	1 Natural 5 Pending 2 Accident investigati	(Month, Da	ay, Year)	Injury	Wor	k?  Yes 2□No	Zou. Describe ii	ow injury occurred	
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification: To	3 Suicide 6 Could not 4 Homicide determine	be 280 Place of Ini	jury - At ho tc. <i>(Specif</i> y	ome, farm, str y)	reet, factory, office		28f. Location (S City or Tow		r Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Director completely filled in I	Medical C		Physician: To the best aminer: On the basis of and manner st	of examina						
	To the within To the Comp	Me	29b. Signature and title of certifier				29c. Licens			29d. Date signed (M	onth, Day, Year)
			Jahli MO				20	063498		7-6-0	9
_			30. Name and address of person wh	WADHWA	2	400 W		nth Stree	t, Frede	rick, MD	21701
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registr	luw	ture	back	,			

DHMH 17 Rev 1/2001

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2009 Month Robinson 8:50 p. The1ma Katherine Soper June 21, 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Calvert Prince Frederick Calvert Memorial Hospital Date of Birth (Month, Day, Year) 12/09/1907 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) Months Days Hours 1 □ M 2 🕅 F 101 213-12-7711 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Yes 2 □ No North Beach MD Calvert 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20714 4048 9th Street 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Town of North Beach 12 Treasurer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cranford Emily Elizabeth 0wen Bristol Soper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3410 Ponds Wood Court, Huntingtown, MD Marsha King, daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal From State Emmanuel U.M. Cemetery 06/27/09 | Huntingtown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. Sign are of Funeral Service Licens 8325 Mt. Harmony Lane, Owings, MD hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23a. Part1. Enter the dise shock, or heart failu Immediate Cause (Final KIGHT CEREBRO VASCULAR disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Year in the past 12 months? Month Day 4 □ Pregnant at time of death 5 ☐ Other (specify)

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

"natural", or items 23a or

event, the Medical

of Health and Mental H fitem 27 Is marked oth r other traumatic even

permit. Pages 1 Department of H Important: If ite any injury or ot once. Directo

Funeral

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Completed

Be

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Examiner

by Physician/Medical

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Certification: To

Medical

Pages 1 and 2 should be filed within 72 hours after death with the Marylanc

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760

9 Unknown	9LJUnknown							
Hreperte	s contributing to death but not resulting in the t		23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown					
Sik.	Ems Lyndon	ne	24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ NO 1 ☐ Yes 2 ☐ NO					
25. Was case referred to medical		26. Place of Death Che						
examiner? 1 Yes 2 No	Hospital: 1 Impatient 2 ER/Outpatie	ent 3 DOA Other: 4 Nursing Ho	e 5 ☐ Residence 6 ☐ Other (Specify)					
27. Manner of Death  1 Natural 5 Pending 2 Accident investiga		of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how injury occurred					
3 Suicide 6 Could no 4 Homicide determin		treet, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
			and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)					

dkw 5

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mukesh Mathur, M.D., 110 Hospital Rd., Suite 305, Prince Frederick, MD 20736

29c. License number

435

29d. Date signed (Month, Day, Year)

22109

31. Date filed (Month, Day, Year)

29b. Signature and title of certified

32. Registrar's Signature

UN 25 2009 Denus B. parks

Registrar

			1 - For State Registrar	State of Ma	aryland		rtificate of t	reaith and i Death		Reg. No	21111	9 22/08
	Physici	an	1. Decedent's Name (First, Midd	dle, Last)				-	2. Date of De Month	ath	av Year	3. Time of Death
	/Medic		LEONARD	JOHN RUSNAK			-		JULY	5,	2009	10:20 PM
	Examin	er									c. County of Dea	
	Funeral		5. Social Security Number	6. Sex 7. Aq	je (In yrs. las	t birthday)	FREDER I	If Under 24 Hrs.	8. Date of Bir	th	FREDER	thplace (State or Foreign
	Director		190-05-2123	1 <b>½</b> M 2□ F	96	Yrs.	Months Days	Hours Min.	8. Date of Bir 9-9-19	12		PA PA
	land <b>ow</b>		Usual Residence of Decedent  10a. State 10b. Count	у	10c. City, 7	Town or Lo	cation					10d. Inside City Limits
	Mary a-f sh	ctor	MD Fred	derick	Fre	ederio	ck					1 □ Yes 2 No
	or 28	Dire	10e. Street and Number				10f. Zip Code				itizen of What Co	ountry?
	s 23a	Funeral Director	8219 Fox Hunt				2170				ISA	
10	ter de item	Fun	<ol> <li>Marital Status</li> <li>Never Married 2  Ma</li> </ol>	12. Was Decedent Armed Forces? 1 XYes 2 ☐ I		13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	)	14. Race - Ame Black, Whit	
036	urs af	þ	3 ₩ Widowed 4 Divorce	If Yes, Give		1	I∐Yes 2⊠No	Specify:			Specify: W	hite
5-0	72 ho	eted	15. Decede (Specify only high	ent's Education lest grade completed)		16a. Deced	dent's Usual Occup	ation during most of work f)	ing	16b. l	Kind of Business	/Industry
21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Evaning must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Press		1)		110	Gov't	(CPO)
ld 2	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, Ire Ma	BeC	17. Father's Name (First, Middle	, Last)		TLCS	Smari	18. Mother's Name	e (First, Middle			(010)
Maryland	uld be Menta Irked Itic ev	2 B	John Rusnak		Agnes Ratta							
lar		( 1)	19a. Informant's Name/Relation	* * * * * * * * * * * * * * * * * * * *	-1		-	and Number or Rui				Zip Code)
	t. Pages 1 and 2 tment of Health tant: If item 27 jury or other tr		Mary Margaret 2	Zemrose Daug				Court Fr	ederick Date		21702 ocation - City or	Town State
nor			1 X Burial 2 ☐ Cremation	3 ☐ Removal from State			sition (Name of natory or other place	7-9-2			-	
Baltimore,			4 ☐ Donation 5 ☐ Other (	The second of the second	PIL.		ort Cem.  . Name and Addres	ss of Facility Kee				, Virginia F H
ä	permir Depar Impor any in	1 19	1 John G	M01176 106 East Church Street Free								
			23a. Part Enter the disease, of shock, or heart failure. Lis	or complications that caused at only one cause on each li	d the death. ne.	Do not ente	er the mode of dyin	ng, such as cardiac	or respiratory a	ırrest,		Approximate Interval Between Onset and Death
burn,	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Gra	stric	cbl	erdin	+				1 MOUTIT
-	/Medical Examiner		rocalling in coally	Due to (or as	a consequer		L					
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	, -							
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury that initiated events	С								
50,	be exectan a	Ë	resulting in death) Last	Due to (or as	a consequer	nce of):						
68760,	rificate be executed ng physician and as the burial-transit	ledical		d								
			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnanc						23d. Date of de	elivery
0.B	The law requires that the death cel ate has been signed by the attendir bage 2 should be detached for use	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown			Ectopic pregnance Other (specify)	у			Month	Day Year
P.(	that the dended by the a		g ☐ Unknown  Part II. Other significant condit	tions contributing to death h	ut not resultin	na in the ur	nderlying cause give	en in Part I	23e Did t	tobacco	use contribute t	o the cause of death?
Records,	w requires to been signer should be o	d by	Cormy	arter.	2120	94	ine in ying daada giri		1 🗆			robably 4 Unknown
000	w requ	lete	rheur	told ar	the, 1				24a. Was	an	24b. Were a	utopsy findings available
B	The larate has page 2	Completed	000	STATE CL	in-				auto perfo 1 □ Yes	psy ormed? 2 N	death?	completion of cause of s 2 □ No
Vital	Physician: The this certificate al director, pag	Be C	25. Was case refe red to medic examiner?	al	.,	•		26. Place of Deat				
of \	is dir	ဥ	1 ☐ Yes 2/15 No		ent 2 EF			4 Li Nursing Ho			6 ☐ Other (Spe	ecify)
	ding I h. After funer	tion	27. Manner of Death  1	ing 28a. Date of Inju (Month, Da tigation		8b. Time of Injury	Worl	yat ⟨? Yes 2 □ No	28d. Describe	how inju	ury occurred	
Division	Attending r death. ector: After by the fune	ifica	3 ☐ Suicide 6 ☐ Could	d not be 28e. Place of Injuried	ury - At home	e, farm, stre	eet, factory, office	103 2 110	28f. Location (	Street a	ınd Number or R	ural Route Number,
Ö	tal or safte al Dire	Certification:	4 ☐ Homicide deter	bullaing, et	c. (Specify)				City or To	wn, Stai	te)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one)	ring Physician: To the best al Examiner: On the basis o and manner sta	of examination	edge, death n and/or in	n occurred at the tir vestigation, in my o	me, date and place, pinion, death occur	, and due to the red at the time,	cause( date ar	(s) and manner and place, and du	s stated. e to the cause(s)
	To the I within 2 To the I complet	Me	29b. Signature and title of certifi				29c. Licens	e number		29d. D	ate signed (Mon	th, Day, Year)
			> Cust	in Learn	e		Do	9680	7		7161	09
			30. Name and address of person	n who completed cause of d	death (Item 2			1		704		
90		to	Dr. A. Austin 31. Date filed (Month, Day, Year	r) 32. Registr	0 West		Street F	rederick,	, MD 21.	\OT		
	Sta Registr		JUL	1 0 2009 > /2	hour		Souls.					

**ORIGINAL** 

)6<sup>†</sup> DHMH 17 Rev 1/2001 DIL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2:05 PM 2009 William Richard Snyder une 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington Washington Co. Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Social Security Number **½** M 2 □ F 84 157-18-1591 12/3/1924 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 XYes 2 □ No MD Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21740 1135 Luther Dr. 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No1 943 − If Yes, Give Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married 1 ∐Yes 2X No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) principal public schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Daniel L. Snyder Edna Cassel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gisela Snyder (Wife) 1135 Luther Dr., Hagerstown, MD 21740 20c. Location - City or Town, State 20b. Place of Disposition (Name of commetery, Garrier place)

Resthaven Memoria 16/26/2009 Frederick, MD 20a. Method of Disposition 1 K Burial 2 Cremation A Removal from State 4 Denation 5 ☐ Other (Specify) Fun ral Service Lic ture <sup>22</sup>Donald B. Thompson Funeral Home POB 18, Middletown, MD 21769 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Part 1. E fer the disease of complication shock, heart failure. List only one car in me firste Cruse (Final disease or condition resulting in death) Hendons Sho dural Due to (or as a consequence of): CERTIFICATION APPROVED BY NELICAL EXTENSION Grand Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c, If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy Duy mility of performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐Yes 2☐No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Menth, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1130 AM Tipped over 09/09 1 ☐ Yes 2 No Wheelchair 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Num r or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
LISI de of dental of S 4 Homicide aineo Dr. sidewalla

Box 68760. o ۵ Division of Vital Records,

burial-transi and physician a requires that the death certificate be ò signed by the a cate has I page 2 s certificate this After t Hospital or Attending 4 hours after death. •uneral Director; Aft ely filled in by the fun 24 hours a within 2

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

**Funeral** 

Director

s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mentai Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, I'm Medical Evel, I'm I'must

permit. Pages 1 and 2 Department of Health a Important; If item 27 is any injury or other trai once.

**Physician** 

/Medical

Examiner

Examine

Physician/Medical

by

Completed

Certification: To

Medical

29a. Certifier

(Check only one)

Baltimore, Maryland 21215-0036

Registrar

VASANT 31. Date filed (Month, Day, Year) JUN 23 2009

29b. Signature and title of certifier



and manner stated.

-att and

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

0 (8019

29d. Date signed (Month, Day, Year)

MACERITOWN

JUNE 20 2009

MD2174

State of Maryland / Department of Health and Mental Hygiene 2 1- State Registrar Amend 1 per Dr. g893 7/10/09 Killicate of Death Reg. No. 1. Decedent's Name (First, Middle, Last)

Derek Squirrel 2. Date of Death 3. Time of Death Month **Physician** 1931 March 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Sinai Hospital of Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours none Director maryiand Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d, Inside City Limits or 28a-f show artment of Health and Mental Hygiene.
ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show
injury or other traumatic event, the "medical Exall and to use the notified at Baltimork Yes 2 □ No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3625 Oak AVE. 2120 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 DNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NONE none none MONE permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item Z7 is marked othr any injury or other traumetha 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Shana Clay ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Md 21215 2401 Sinai W. BEIVEDERE AVE, HOSPITAL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hespira C 23 22. Name and Address of Facility Sina, Hospital of Baltimore 21. Signature of Funeral Service Licensee DisposA 2401W. Belverer Ave Baltimore, MD 21215 Approximate interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** a Pulmonary hemorrhan MINUTES /Medical Due to (or as a consequence of): Examiner piratory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last requires that the death certificate be execute physician and s the burial-tran Box 68760, Physician/Medical attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.O. been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 3 Probably 4 Unknown 1 Tes Be Completed Hypernatremia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page 2 s autopsy certificate perform of Vital 1 ☐Yes 2 ☐No 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 24 hours after deatl Funeral Director: filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ca 29a. Certifier (Check only one) within 2 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) DOO61593 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 W. BELVEDERE AVE.
Baltimore, md 21215 Sinai Hospital 31. Date filed (Month, Day, Year) 37. Registrar's Signature State Registrar **3 0 MUL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Month June 15 1. Decedent's Name (First, Middle, Last) Day 2009<sup>Year</sup> Verena Lisa Savoy 15, РМ 14:45 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Washington Adventist Hospital Montgomery Takoma Park If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 □ M 2 🖺 F Months Days 213-66-4404 54 Aug. 8, 1954 Washington, DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits

**Funeral** Director 

**Physician** 

/Medical

Examiner

10a. State

Physician

/Medica

Examine Division of Vital Records, P.O. Box 88760, To the Hospital or Attending Physician: The law requires that the death certificate be executed

5	MD	Montgome	ery	Silve	r Spri	.ng						'2	Z res 2 INO
ire	10e. Street and Nu	mber				10f. Zip Code				10g. Citi	zen of What	Country?	
ral	1000 Dev	ere Drive	ž			20901	l			USA			
nue	11. Marital Status		12. Was Decedent I Armed Forces?		13. Wa	s Decedent of es, specify Cub	Hispanic ban, Mexi	Origin? (Speci	fy Yes or No-		14. Race - Ai Black, Wi		dian,
Completed by Funeral Director	1 ☐ Never Marr 3 ☐ Widowed	ied 2  Married 4	1 □Yes 2★ N If Yes, Give Year or Dates:	No		]Yes 2 <mark>k</mark> ∏No					Specify:	B1ac	ck
ete	(Spec	15. Decedent's E	ducation ade completed)		(Give kir	nt's Usual Occu and of work done	during m	nost of working		16b. Ki	nd of Busines	ss/Industry	
귵	Elementary/Seco		College (1-4or 5	5+)	life. DC	NOT use retire	ed)			ת המ		a . t	. 1
ပ္ပ	17. Father's Name	(First Middle Last	5+		Princ	ipai	18 Ma	other's Name (/			ublic	School	ors
To Be		P. Savoy,	*				1	rva Hur		Maiden	<i>Ourname</i>	-	
ľ		ame/Relationship	(Type. Print) III(Brothe		19b. Mailing 7125 R	Address (Stree	and Nur	nber or Rural I	Route Numbe	er, City o	r Town, State	e, Zip Code .044	)
	20a. Method of Dis		TIT(DIOCHE		e of Disposit	ion (Name of tory or other pla		6/23/20	500	20c. Lo	cation - City	or Town, S	tate
		☐ Cremation 3 ☐ 5 ☐ Other (Special	Removal from State	1		morial				l and	over.	MD	
		uneral Ser Line		1	22.1	Name and Addr	ess of Fa	cility McGu	ire Fu	nera	1 Serv	ice.	Inc.
	Fyn	ne 1h	u frese		740	0 Georg	gia A	ve., N	.W. Wa	shin	gton,	D.C.	20012
	23a. Part 1. Enter t	the disease, or com	polications that caused	the death.	Do not enter	the mode of dy	ing, such	as cardiac or i	respiratory ar	rest,		Appr	oximate val Between
	Immediate Cause disease or condition	(Final	( )	70h		emb	olis	m				Onse	et and Death
	resulting in death)	•	Due to (or as			1	W.	1.1					
L	Sequentially list co	nditions.	D	OXIC	enc	epha	lop	athy					
Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated events	erlying	Due to (u) as	a consequer	no of).	1.	1.	J					
хап	that initiated events resulting in death)	Last	cDue to (or as	STIT	rce of):	ung	ar	sease	-			-	
<u>8</u>		l		east		mcer	-						
edic			a.										
Completed by Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 ☐ Yes 2 ( 9 ☐ Unknown	months?	23c. If yes, outcome 1  Live birth 4  Pregnant a 9  Unknown	2 Fetal de	eath 3 🗆 E	Ectopic pregnan Other (specify)				:	23d. Date of Month	delivery Day	Year
P.	The state of the s		contributing to death be	ut not resultir	ng in the unde	erlying cause gi	iven in Pa	rt I.	23e. Did to	bacco u	se contribute	to the cau	use of death?
ed by						, , ,			1□Y	'es 2[	□No 3□	Probably	4. ☑ Unknown
plet									24a. Was		24b. Were	autopsy fi	ndings available ion of cause of
ĕ									perfo	med?/ 2 No	death	io complet i? ′es 2 □ l	
Be (	25. Was case refer examiner?	red to medical						ace of Death (		ne)		-	
ြို	1   Yes 2			ent 2 EF		3 LI DON		Nursing Home	5 ☐ Resid	lence (	6 ☐ Other (S	Specify)	
ation:	27. Manner of Deat  1. Natural 2 Accident	5 ☐ Pending investigatio	I	ry, Year)	3b. Time of Injury		ury at ork? ⊒Yes 2		d. Describe h	ow injur	y occurred		
ertific	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined		ury - At home c. (Specify)	e, farm, stree	t, factory, office		28	f. Location (S City or Tow	Street an In, State	d Number or )	Rural Rou	te Number,
Medical Certification:	29a. Certifier (Check only one)	Certifying Pl	hysician: To the best miner: On the basis o and manner sta	of examination	edge, death on and/or investigation	occurred at the stigation, in my	time, date opinion,	e and place, and death occurred	nd due to the I at the time,	cause(s date and	) and manner d place, and d	r as stated due to the o	cause(s)
Me	29b. Signature and	title of certifier	200			29c. Licen	se numbe			29d. Dat	te signed (Mo	onth, Day,	Year)
			1411)				000	14-1			0/16	1200	7
		ress of person who	completed cause of d	leath (Item 2:			AL IEN	1111= -	AKAR	D /	PAPK	MI	2000

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 06 Physician 16 2009 5:37A M Annie V. Butler Simmons /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Takoma Park Washington Adventist Hospital 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months Days Hours Min. 1 □ M 2 🕅 F 8/16/1908 MD 578-26-3904 100 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertal Hygiene.
ant. If tem 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, In The Ment Teraminer must be notified at 10d. Inside City Limits 10c. City, Town or Location 1 XYes 2 ☐ No Director Prince Georges Hyattsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5821 Queens Chapel Rd. #103 20783 United States by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Specify: Black Saltimore, Maryland 21215-0036 1 ∐Yes 2X No Specify: 3 ₩ Widowed 4 □ Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Butler Annie Blackiston ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1800 Metzerott Rd., #201, Adelphi, MD Romaine S. Stanton/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Department of Important: If it any injury or conce. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State St. Charles Cemetery 6/26/2009 Glymont, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McGuire Funeral Service. Inc. 21. Signature of Funeral Sec 7400 Georgia Avenue, NW, Washington, DC 20012 grances Approximate Interval Between Onset and Death 23a / art1. Enter the use se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart aily e. List only one cause on each in the cause of the Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 - Ectopic pregnancy After this certificate has been signed by the atte funeral director, page 2 should be detached for Month Year 5 Other (specify) 1 □Yes 2 ☑No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 □Yes 2 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 □ Yes 2 🗆 No 2 Accident fter death 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide

To the Hospital o within 24 hours of To the Funeral Di

29a. Certifier

(Check only one)

29b. Signature and title of

DHMH 17 Rev 1/2001

State Registrar and manner stated

who come

leted cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 19.Day June<sup>Month</sup> 200 gai **Physician** 6:15A. Virginia F. Saunders /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Beltsville Prince George's 11358 Evans Trail, #101 8. Date of Birth (Month, Pay, Oct. 11, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 82 Pennsylvania 1□M **¾**□F 200-16-6319 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits death with the Maryland 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 No Prince George's Beltsville Maryland Director 10f. Zip Code 20705 10g. Citizen of What Country?
United States 10e. Street and Number 11358 Evans Trail, #101 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Iten any Injury or other traumatic event, the Medical Examiner 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: <u>ک</u> 3 ☐ Widowed 4 ☒ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Printing Office Congressional Documents Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Winifred Ramsey Frisbie Williəm ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. Box 709 Hawley, PA 18428 Lorraine Nagel -Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery 6/24/2009 Brentwood, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Function lervice (icensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Ma Maryland20705 disease, or con or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Part1. Enter he diseas shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Breast Malignant Neoplasm Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Emer underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner lor Attending Physiclan: The law requires that the death certificate be executed and as the burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Be Completed by Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 1€ months? 1 □ Yes 2 ② No Month Day Year 5 Other (specify) the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? filled in by the funeral director, page 2 should be 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2 ANo 1∏ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 Vo 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 ☐ Homicide e Funeral I the Hospital 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and titlers certified e 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

**JUN 24** 

32 Registrar's Signatur

rds, P.O. Box 68760, pures that the death certificate be ex	Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certificate
	tal Re

	1	For State Registrar	iease	State of		nd / De <sub>l</sub>	partment ertificate	of He	ealth a		ental Hy		0000	22114	
Physicia	n	1. Decedent's Name (First, I		•					-		2. Date of De Month	ath Day	Year 2009	3. Time of Death	
/Medica Examine	r	4a. Facility Name (If not inst	itution, gli	ve street and nu	PAL C	lenter	4b. City, To	54	Alsbu	14	<del>-</del>	4c.	County of Dea	th .	
Funeral Director		5. Social Security Number 059–32–0319		Sex 1 DXM 2 □ F	7. Age (In yr 67	s. <i>last birthda</i> Yrs.	Months	Days	If Under Hours	Min.	8. Date of Bir 9/6/19	41 Year)	9. Bir	thplace (State or Foreign ountry) NY	
Maryland f show	Ī	Usual Residence of Decede  10a. State 10b. Co		ter		City, Town or								10d. Inside City Limits 1 □ Yes 2 🖔 No	
with the ?3a or 28a-	Funeral Director	10e. Street and Number					10f. Zip C					_	zen of What Co	Duntry?	
I's a	2	11. Marital Status  1 Never Married 2 Dividence   3 Dividence   4 Dividence   2 Dividence   3 Dividence   3 Dividence   4 Divide	Married	12. Was Dec	2 <b>X</b> No ive	U.S. 1	3. Was Decede If Yes, specif		panic Or , Mexicar Specify:		ecify Yes or No Rican, etc.)	)-	14. Race - Am- Black, White Specify:		
within 72 ho giene. r than "natur	Completed	15. Dec (Specify only of Elementary/Secondary (0		rade completed,	1-4or 5+)	(Gi	cedent's Usual ve kind of work DO NOT use	done du retired)	<i>uring m</i> os	st of workin	ng		nd of Business utomoti	·	
uld be filed Mental Hyg arked othe atic event,	10 Be C	17. Father's Name (First, Mi Henry Shara	ddle, Las	t)					E.	lizab	(First, Middle beth Br	own			
and 2 sho saith and 27 is ma er trauma		19a. Informant's Name/Rela				1304	ailing Address ( McHenr	ry C⊤	t., (	Ocear	Pines	, MD	21811		
Pages 1 ment of Ho ant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth					sposition (Name rematory or oth nlopen			6/25	oate 5/09	Fr	ankford	, DE	
permit. Departi Import any Inj		21. Signature of Funeral de	NA	Durbo	ele_			illia	am S	t., E	Berlin,	MD	eral Ho 21811	me	
Physician		23a. Part 1. Enter the disea shock, or heart fallure Immediate Cause (Final disease or condition	se, of con List only	y one cause on	each line.		enter the mode			s cardiac o	or respiratory a	arrest,		Approximate Interval Between Onset and Death	
/Medical Examiner		resulting in death)  Sequentially list conditions.	ſ	Due to	(or as a cons	equence of):	Intra	Va	9 w v 1	ler	Coogs	jat	207	2 weeks	
	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	c. Due to	o (or as a cons	equence of):	Intra Prost	to ke	: (	Cenc				2 years	_
leath certificate attending phys		IF FEMALE:		23c. If yes. o	utcome of preg	nancy						T	23d. Date of d	elivery	_
the death y the atter ched for u	Physician/Medi	23b. Was decedent pregna in the past 12 months' 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		1 🔲 Live	birth 2 Pe gnant at time o	etal death	3 ☐ Ectopic pre 5 ☐ Other (spe						Month	Day Year	
law requires that the de as been signed by the 2 should be detached	ן הַ	Part II. Other significant co	nditions	contributing to	death but not r	esulting in the	e underlying ca	use give	n in Part	l.		tobacco	u ac	to the cause of death? Probably 4 ☐ Unknown	1
Attending Physician: The law requires that the death certificat ar death. ector: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the	Completed										24a. Was auto perf 1 □ Yes	opsy ormed?	prior to death?	utopsy findings available completion of cause of s 2 □ No	,
s certif	o Be	25. Was case referred to m examiner? 1 ☐ Yes 2 ☑ No	edical	Hospital:	Inpatient 2	□ ER/Outpa	tient 3 DO				n <i>(Check only</i> me 5□ Res		6 □Other (Sp	ecify)	
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification: To	27. Manner of Death 1 ★Natural 5 ☐ F 2 ☐ Accident	ending nvestigation	28a. Date (Mo	e of Injury nth, Day, Year	28b. Time Injur	e of 28	Bc. Injury Work? 1 □ Y	at	]No	28d. Describe	how inju	ry occurred		
ital or Att		4 ☐ Homicide	etermine	d 28e. Plac build	ding, etc. (Spe	ecity)	street, factory,				City or To	wn, State	<del></del>	Rural Route Number,	
the Hosp hin 24 hou the Fune appletely fil	Medical	(Check only 2 Me	dical Exa		ne best of my basis of examiner stated.	knowledge, d ination and/o	r investigation,	in my op	ne, date a pinion, de 	and place, eath occur	and due to the	, date an	and manner d place, and du  te signed (Mor	ue to the cause(s)	_
7 wit oo o	4	29b. Signature and title of o			M. 0		2	03	06			J	~ 21	,2009	_
D) 4 10		30. Name and address of p  Jone 5 E.  31. Date filed (Month, Day,  JUN 2	MA (	o completed car	M. D.	tem 23a) (Ty	E. C	err	011	57.	,501	1.56	uny n	10 21801	
State Registra		JUN 2	2 4 20	009 1	eyistiars of	A. A	ake		-						_

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/larvin Wayne Si	1	- For State	of Maryland	Departme Certifica			d Menta	R	eg. No.	20	109 221
Physicia	n/	<ol> <li>Decedent's Name (First, Middle,Las</li> </ol>	Simmons			<del>.</del>		2. Date of Dea Month June 23,	Day	Year	3. Time of Death 0350 hrs
Medical Examin		4a. Facility Name (if not institution, giv			4	b. City, Town, or	Location of			County of Dea	th
	H	Route 50 / Elkslodge Road	d			Cambridge				orchester	
Funeral Director		5. Social Security Number 6. Security Number 1X	7. Ag	e (In yrs. last birth	nday) Yrs.	If Under 1 Year Months Day		24Hrs. 8. Date of Bi		0	irthplace (State or Foreign country) MD
any	-	Usual Residence of Decedent  10a, State  10b, County		10c. City, Town	or Locatio	on					10d. Inside City Limits
		MD Dorches	ter			Vie	nna				1 Yes 2 X No
faryland 8a-f sho at once.	Director	10e. Street and Number		L		10f. Zip Code			10g. Citi:	zen of What Co	ountry?
the Nature of the A		4908 Ravenwood	Road				21869		·	USA	
after death with	Funeral	11. Marital Status  1 Never Married 2 Married	1 Yes 2		If Ye	es, specify Cuba	ın, Mexican, İ	n? ( Specify Yes or N Puerto Rican, etc.)	0-	14. Race - American Indian, Black, White, etc. White	
s after ral",	ᇫ		If Yes, Give Year or Dates:	mplotod) 16a		Yes 2 X N		nd of work done	16b.	Specify: Kind of Busines	s/industry
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner, must be notified at once	Completed	15. Decedent's Education (Specify of Elementary/Secondary (0-12)	College (1-4 or		during me	ost of working lif electri	e. DO NOT u	ise retired)			ruction
21215-0036 and be filed within 7 Mental Hygiene. marked other than e event, the Medica	틩	17. Father's Name (First, Middle, Last	)				18.Mother's	Name (First, Middle	, Maiden	Surname)	
21215 hould be file and Mental H is marked of titic event, the	Be	Leroy Stewart S					-	ve Mae Wa			. 7: 0.1.)
should be filed with and Mental Hygiene 7 is marked other t	유	19a. Informant's Name/Relationship ( Marie Simmons		- 10				per or Rural Route No pad, Vienn			
ore, MD ses I and 2 show of Health and If item 27 is ther traumatic	H	20a. Method of Disposition	W.	20b. Place	of Dispos	ition (Name of c		Date Date		Location - City	
Baltimore, permit. Pages 1 at Department of Hee Important: If ite		1 X Burial 2 Cremation 3 4 Donation 5 Other Specific	c _	alc	este	her place) er Mem. Name and Addre		6/27/09		ambrido	
Ball permit Depar Impor		21. Signiture of Funeral Service Lice	nsee					Thomas F			
Physician		23a. Firt I. Enter the disease, or com	plications that caused	the death. Do n	ot enter the	he mode of dyin	g, such as ca	ardiac or respiratory a	rrest, sh	ock, or heart	Approximate Interval Between Onset and
Medical xaminer		făilure. List only one cause on e Immediate Cause (Final disease a	ach line. .Head and Neck	(Injuries							Death
Adminier		or condition resulting in death)	Due to (or as a cons	sequence of):							
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	sequence of):							
	Examiner	(Disease or injury that initiated	Due to (or as a cons	equence of):							
ansit		events resulting in death) Last	,	sequence or).							
50, te be executed ysician and burial - transit	edical	UNPENDED	AMENDED								
760, icate be physici the buri	/Mec	IF FEMALE: 23b. Was decedent pregnant in the		ome of pregnancy			Estopio	pregnancy	23	3d. Date of deliversely	very Day Year
c 6876 certificate ending phy use as the l	sician/M	past 12 months?	1 Live birth 4 Pregnant a	t time of death		etal death ther (Specify)	Ectopic	pregnancy		World	Day Tour
Records, P.O. Box 6876i The law requires that the death certificate icate has been signed by the attending phy page 2 should be detached for use as the b	Physi	1 Yes 2 No 9 Unknow	9 Olikilowii								to the course of doubts?
.O. that the eed by	by PI	Part II. Other significant conditions	contributing to dea	th but not resulting	ng in the	underlying caus	e given in Pa			✓ No 3	to the cause of death?  Probably 4 Unknown
S, F quires t								24a. Wa			autopsy findings available
aw red	ple								topsy rformed	deatl	
Rec The icate	Completed		-			OC DI	on of Death	1 ✓ Ye (Check only one)	s 2	No 1 🗸	Yes 2 No
ital sician: s certi	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpat	ient 2 ER/0	Outpatien		Other 4	Nursing Home 5	Resid	dence 6 🗸 O	ther: Scene
1 of Vital Records ling Physician: The law requi After this certificate has been funeral director, page 2 should	 7	1 Ves 2 No 27. Manner of Death	28a. Date of In	jury 28b	. Time of		njury at Work	? 28d. Descrit	e how in	njury occurred	er collision
OD on sath	tion	1 Natural 5 Pending 2 ✓ Accident Investiga	Jun 23, 200	9' 6 033	35 hrs	1_	Yes 2 🗸	No Driver sin	gie vei		El Collision
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that th within 24 hours after death To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detach	Certification:	2 Accident Investigat 3 Suicide 6 Could not determine	at be 28e. Place of	Injury - At home, ajor Road / H			e building, et				r Rural Route Number, City mbridge , MD
To the Hosp within 24 hos To the Fune completely fi	Medical C	29a. Certifier 1 Certifying Physi	cian: To the best of er: On the basis of ex	amination and/or	eath occu	urred at the time ation, in my opin	, date and pla ion, death oc	ace, and due to the cocurred at the time, da	ause(s) a ate and p	and manner as place, and due t	stated. to the cause(s)
To Wiji	Me	29b. Signature and title of certifier	And marrier states				ense number				(Month, Day, Year)
		Allen Granel	1, MID			0.	C.M.E.		Ju	ine 23, 2009	<del>.</del>
CME		30. Name and address of person who Melissa Brassell, MD	o completed cause of Assistant Medic			Penn Street	, Baltimor	e, MD 21201			
	tate	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	4	a. Wal					
Regis		2014 80	Will Com	un p.	PICIT	arked					
DHMH 17 Rev 1/2	U01			0	RIGINA	AL					

			Please Type or Prin						_	
			State of Ma  For State Registrar	iryland /		rtificate of L			ene g. No. 2	9 22116
	111	7	1. Decedent's Name (First, Middle, Last)					Date of Death     Month	Day Year	3. Time of Death
	Physicia /Medic	_	Anna Taylor					June	19 2009	2:40 P M
8	Examin	- 1	4a. Facility Name (If not institution, give street and number)			4b. City, Town, or	Location of Death		4c. County of Dea	th
rÆ.			Coastal Hospice At The Lake			Salisbur			Wicomico	
	Funeral		1 DM 2 X E 0	(In yrs. last b		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)   C	thplace (State or Foreign ountry)
L	Director		140-12-4336	/	Yrs.			Nov. 8,	1911   Pen	nsylvania
	and t		10a. State 10b. County	10c. City, Tov	vn or Lo	cation				10d. Inside City Limits
	Maryl	ō	Maryland Wicomico	Pitts	svil	le				1 □Yes 2 No
$\tilde{a}$	r 28a	rec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
J	n with	Funeral Director	34124 Old Ocean City Road				21850		US	SA
	deat	ner	11. Marital Status 12. Was Decedent E	ver in U.S.	13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No-	14. Race - Am Black, Whi	
و	after or Ite		Armed Forces?  1 □ Never Married 2 □ Married    If Yes 2 □ N  If Yes Give	lo	1		Specify:	,,		White
21215-0036	ours ural",	d by	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates:					1.		
2	72 h "natu dica	ete	15. Decedent's Education (Specify only highest grade completed)	168	a. Deced (Give	dent's Usual Occupa kind of work done o DO NOT use retired	ation during most of work	ing 1	6b. Kind of Business	s/Industry
2	within sne.  than  e Me	Completed	Elementary/Secondary (0-12) College (1-4or 5-	+)		emaker	/		Own Hon	10
2	Hygie Ther 1	ပိ	17. Father's Name (First, Middle, Last)		HOM	ellakei	18. Mother's Nam	e (First, Middle, M		
anc	antal ed o	) Be	(First Name Unknown)	Was	gner		Unknow	n		
Maryland	should Me Me mark	<b>1</b> 0	19a. Informant's Name/Relationship (Type. Print)		_				City or Town, State,	Zip Code)
S S	nd 2 sullth ar		Edith A. Smack/Daughter	3	3410	4 01d Oce	an City	Road, Pi	ttsville,	MD 21850
ē,	iges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Hygiene. It of Health and Mental Hygiene. It was a so a case of show or other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition			sition (Name of matory or other place			20c. Location - City o	
Baltimore,	Pages nent of int: If Ite		1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation _5 ☐ Other (Specify)			of Delman	1	/2009 1	Delmar, De	laware
= = =	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Ligenage	71						
ä	any any one		Secured of gel	ew	ΙÍ	212 01d 0	cean Cit	y Road,	Salisbury,	MD 21802
п	100		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one pages on each lin	the death. Do	not ent	er the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
<b>.</b>	hysician		File On the (Fired		GN	ICID (	ARCI	NOMA		Onset and Death
100	/Medical			a consequence						
Ю	Examiner		Sequentially list conditions b							
	g ÷	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a consequence	e of):					
	e executed sian and urial-transit	kam	that initiated events resulting in death) Last  Due to (or as a	a consequence	of).			-		
60,	be ey ician burial	-	Buo to (61 da 1	a consequence	3 017.					
687	Attending Physician: The law requires that the death certificate be executed refeath. The death refeath. exters the third physician and ector. After this certificate has been signed by the attending physician and yot the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica	d							
×	certif nding Ise as	/Me	IF FEMALE: 23c. If yes, outcome						23d. Date of d	elivery
. Box	death atter	ciar	in the past 12 months?  1□Voc. 3□No.  4□Pregnant at			⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>	/		Month	Day Year
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O.,	N requires that the debeen signed by the should be detached	by PI	Part II. Other significant conditions contributing to death be	ut not resulting	in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
ğ	quire an sig uld b							1 □ Ye	es 2∭ENo 3∏I	Probably 4 □Unknown
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ř	The late ha	шо						autops perforn	ned? death?	-1-
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r <	nysician: The law his certificate has b I director, page 2 s	To E	examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatie	ent 2 ER/C	Outpatie	nt 3 DOA Oth	er: 4 □ Nursing H	ome 5 ☐ Reside	nce 6 Other (Sp	ecity) Hospice
0	ding Ph  After th funeral		27. Manner of Death 1 X Natural 5 ☐ Pending 28a. Date of Inju (Month, Day	ry 28b y Year)	. Time o	of 28c. Injur Wor	y at k?	28d. Describe ho	w injury occurred	·
0	ttendii leath. tor: A the fu	atic	2 Accident investigation				Yes 2 ☐ No			
Division or	or Attendate death Director: in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injubiliding, etc	ury - At home, c. <i>(Specify)</i>	farm, st	reet, factory, office		28f. Location (St. City or Town	reet and Number or i n, State)	Rural Route Number,
	pital o		29a, Certifier 1. Certifying Physician: To the best of	of my knowled	ao dos	th accurred at the tir	mo date and place	and due to the e	auco(e) and manner	as stated
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in I	Medical	29a. Certifier 1 Certifying Physician: To the best ( (Check only one) 2 Medical Examiner: On the basis of and manner sta	f examination a						
	<b>To the</b> within 2 <b>To the</b> comple:	Med	29b. Signature and title of certifier			29c. Licens	e number	2	9d. Date signed (Mo	nth, Day, Year)
	⊢ s ⊨ ō		Seeming h. 1	Sella	- 4	ED D 2	29505		06/29	109
			80. Name and address of person who completed cause of d	eath (Item 23a	) (Type,	Print)				
		(	GREGORIO M. BELLO	50, M.	P.; 5	302 (H	INABER	RY DR.,	SALISBRI	ZY, MD 21801
	Sta		31 Date filed (Month, Dav. Year)   32, Hadisti	ar s Signature				-		
	Registi	ar	JUN 86 2000 Am	m B.	4	NOVE -				

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009<sup>ear</sup> **Physician** 22. Margaret L. Tolzman June 7:05A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Renaissance Gardens at Riderwood Silver Spring Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth May 24, 1919 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ м 2 👽 ғ Months Days Hours Min. Maryland 219-07-3347 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show ust be notified at Maryland 1 ☐Yes 2 No Director Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3128 Gracefield Road, #213 20904 United States Funeral Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Evanthating once. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ∐Yes 2**X** If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X** No altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ⋛ White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (022) Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Calvert F. Long ပ Alberta Trossbach 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) August M. Tolzman, Jr. -busband 3128 Gracefield Road, #213 Silver Spring, Md. 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State St. Michael Catholic Church Cemetery 6/26/2009 Ridge, Maryland 4☐Donation 5☐Other (Specify) 21. Signature of Funeral Service Licens Bonalad V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Chronic Lymphocytic Leukemia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if a cause. Enter Underlying cause (Disease or injury that initiated events Due to (or as a consequence of): Exami been signed by the attending physician and should be detached for use as the burial-tranresulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2√2 No 9 ☐ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2√□ No 24a. Was an page 2 has perform certificate 1 □ Yes 2 **X**No 2<mark>X</mark>□No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death Matural 28d. Describe how injury occurred After 5 ☐ Pending investigation Hospital or Attendi 24 hours after death. Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

of Vital Records, P.O. Box 68760, Margarat 5/24/1919 Division

To the Hospital within 24 hours a To the Funeral C 10

> State Registrar

Medical

31. Date filed (Month, Day, Year)

JUN 24

29b. Signature and title of certifier

29a, Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Kundrat, M.D. 3110 Gracefield Road Silver Spring, Maryland 20904

and manner stated

32 Registrar's Signature backer

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D36716

29d. Date signed (Month, Day, Year) June 22, 2009

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JUN 24 2009

Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State RegistrarMFD#23a(a)	State of	Maryland / i	Depar	tment of	Health	and M	lental Hv		2009	22119
Phys		1. Decedent's Name (First, Middle, I Jeanne Bucher Wa	Last)		,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				2. Date of De Month June	eath		3. Time of Death 8:30 P. M
Exan	dical niner	4a. Facility Name (If not institution, g	give street and numi	ber)		4b. City, Town	, or Location	of Death			County of Death	
		Washington Adver	itist Hosp	pital		Takoma	Park			Mo	ntgomer	У
Funer	_		Sex 7	. Age (In yrs. last bi		If Under 1 Yea Months Day		r 24 Hrs. Min.	8. Date of Bir (Month, Da	rth ay, Year)	9. Birth	place (State or Foreign intry)
Direct	or	163-24-9116 Usual Residence of Decedent		83	Yrs.				June 9	, 192	6 Pen	nsylvania
/land	32	10a. State 10b. County		10c. City, Tow	vn or Loca	tion						10d. Inside City Limits
Man)	ģ	Maryland Prince	George's	Bowie								1XYes 2□No
with the Maryland a or 28a-f show	irec	10e. Street and Number				10f. Zip Code	•			10g. Citiz	en of What Cou	ntry?
leath wi	Funeral Director	12512 Knowledge	Lane			20715				Unit	ed Stat	es
er dea	au	11. Marital Status	Armed Forc	ent Ever in U.S. es?	13. Wa	s Decedent o es, specify Cu	f Hispanic Oi uban, Mexica	rigin? (Spe in, Puerto	ecify Yes or No Rican, etc.)	D- 1	<ol> <li>Race - Ameri Black, White,</li> </ol>	
36 s afte	S F	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 □Yes 2 If Yes, Give Year or Dat	-	1 🗆	⊒Yes 2 <b>⊠</b> N	o Specify	<i>r</i> :			Specify:	
15-0036 72 hours after death with the Maryland "natural", or items 23a or 28a-f show coal Eventines out by mortified at	Completed by	15. Decedent's	Education		l a. Deceder	nt's Usual Occ	upation				Whi d of Business/Ir	
within 72 iene.	ple	(Specify only highest of Elementary/Secondary (0-12)	grade completed) College (1-4		(Give kir life. DO	nd of work dor NOT use reti	ne during mos red)	st of worki	ng			
21 ad with gien er the	6	12	- Contage (1 -		ccoun	tant				Acc	ounting	
ind be file tal Hy d oth event	To Be (	17. Father's Name (First, Middle, La.	st)				18. Moth	er's Name	(First, Middle	, Maiden S	Surname)	
Maryland 2121: 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than " traumatic event, the Medicand than "	은	Claire Bucher					Anna	Mar	y Group	oe		
Baltimore, Maryland 21215-0036 bernit. Pages 1 and 2 should be filed within 72 hours att Department of Health and Mental Hygiens. In Item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Eventi		19a. Informant's Name/Relationship	1 21	194	b. Mailing $701~{ m G}$	Address <i>(Stre</i> Gude Av L Park,	et and Numb enue	er or Rura	l Route Numb	er, City or	Town, State, Zi	p Code)
e, l 1 and Healt em 2		Jeff T. Walker,	Son						ate	20c Loc	ation - City or T	own State
ages ant of tt: If it		1 ☐ Burial 2 🛣 Cremation 3		ale		ion (Name of tory or other p Cremato		June			•	
nit. Partme	αŝ	4 ☐ Donation 5 ☐ Other (Special Service Lice)		Attair	22. 1	Name and Add	ress of Facili	2009 itv	<u> </u>		Burnie	
Baltimore, Mapermit. Pages 1 and 2 s Department of Health at Important: If Item 27 is any injury or other trau	OUC OUC	Phrim M  23a. Part 1. Enter the disease, or co shock, or heart failure. List on	"nen		Th	ibadea 3 Gist	u Mort Ave.,	LL,			.A. ing, MD	20910 Approximate Interval Between
Physicia Medica Examine physician and physician and the prival-transit	ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or oue to (or or  r as a consequence	of):	br	Cas	ŧ €	Cancer			Onset and Death	
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cords, P. w requires that the speen signed by should be detacted.		Part II. Other significant conditions	contributing to dea	th but not resulting i	in the unde	erlying cause o	given in Part	l.		tobacco us Yes 2 □		the cause of death?
on of Vital Records, ding Physician: The law requires th. After this certificate has been signe funeral director, page 2 should be o	Completed by								24a. Was auto perfo 1 □Yes		24b. Were auto prior to co death? 1 □ Yes	opsy findings available ompletion of cause of
Vital sician; T scrifficat	Be	25. Was case referred to medical examiner?	Hospital: 🔀					e of Death	(Check only o	one)		
Of Phys	<u>ا</u>	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of	patient 2 ER/O	utpatient Time of	3 DOA					Other (Speci	ify)
on ding h. After funer	ion	1 Natural 5 ☐ Pending	(Month,		Injury	I .	juryaτ ork? ∐Yes 2 ∐		28d. Describe	now injury	occurred	
Division of Attending after death. Director: After din by the fune	Certification:	2 Accident Investigati 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of	   Injury - At home, fa  , etc. <i>(Specify)</i>	arm, street				28f. Location ( City or To		Number or Rur	al Route Number,
Division  To the Hospital or Attent within 24 hours after deatt To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying I (Check only one)	Physiclan: To the baminer: On the bas aminer: and manne	est of my knowledges of examination are retated.	e, death o	ccurred at the stigation, in my	time, date a y opinion, de	nd place, ath occurr	and due to the ed at the time,	cause(s) date and	and manner as place, and due t	stated. to the cause(s)
<b>To th</b> withir <b>To th</b> сотр	Me	29b. Signature and title of certifier				29c. Lice	nse number			29d. Date	signed (Month,	Day, Year)
6		Ayene.	ND			63	5787	)		OF	144/	09
		Adame A	Ilne "	of death (Item 23a)	(Type, Pri	nt)	Ave		Tako	ma	par	1c, nD
Regis	tate strar	31. Date filed (Month, Day, Year)  JUN 24 2	009 Ce 2	vistrar's Signature	par	es!					<i>V</i>	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) June 26, 2009 Janet Gail Yax 6:30 A 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Port Republic Calvert 4430 August Drive 9. Birthplace (State or Foreign Country) Michigan If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, July 9, 5. Social Security Number 7. Age (In vrs. last birthday Days Hours Min. 1 □ M 2 🖵 F 377-36-6207 74 Yrs. Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐Yes 2 No Maryland Calvert Port Republic 10g. Citizen of What Country? 10e. Street and Number 20676 United States 4430 August Drive 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ▼ No Specify: Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Lisual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Census Bureau Survey Statistician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Norman A. Smith Madeleine H. Wohlgemuth 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Kathleen Yax- daughter 4430 August Drive Port Republic MD 20676 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) June 29, Date 2009 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Alexandria Virginia Metropolitan Funeral Service 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Funeral Service Licenses Kausa 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) month olon Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) ☐Yes 2 No 9 Unknown 9 Unknowi 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1∐ Yes 2 No

**Physician** /Medical Examiner Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

Be

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ir than "natural", or items 23a or 28a-f sho

within 72 hours after

permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien Important; If item 27 is marked other that any injury or other traumatic event, In-

Baltimore, Maryland 21215-0036

burial-trar the asn for 1 detached

law requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

and attending physician the ģ has certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Physician/Medical ð Completed Be ပ္ Certification: 27. Manner of Death

Medical 5 m Registrar

31. Date filed (Month, Day, Year) State

1 Matural 2 ☐ Accident

3 Suicide

29a. Certifier

4 Homicide

5 Pending investigation

6 ☐ Could not be

1 Inpatient 2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28a. Date of Injury (Month, Day, Year)

and manner stated.

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

Amend 296 & 29d per MD G893 7/13/09 TT

Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Month Day Year 6:10 PM **Physician** JUli 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Baltimore
If Under 1 Year | If Under 24 Hrs. ospita 7. Age (In yrs. last birthday) 72 Yrs. 8. Date of Birth Month, Day Jan. 28 Birthplace (State or Foreign Country) 6. Sex **Funeral** Hours Days Months 220-32-2878 1 ☐ M 2 💢 F Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Moutcal Examination is neatled at once. 1 Yes 2 No Director MD more 10f. Zip Code 10g. Citizen of What Country? 21215 rark Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3 Widowed 4 Divorced Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Black Specify: þ Specify. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working Me. DO NOT use refired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary Secondary (0-12) College (1-4or 5+) amstress 17. Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Surname, SKe ohn a and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship Balto., MD 20b. Place of Disposition (Name of cemetery, crematory or other plants). The company of the plants of the cemetery crematory or other plants. 20c. Location - City or Town, State 20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) of Funeral Service Licenses reche 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heal Mailure. List only one cause on each line. Immediate Cause (Final Uterine **Physician** Metastatic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Metas Brain Some tielly list out cities if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 □ Yes 2 No 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown icate has been siç ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐Yes 2 ☐No 1 □Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After this 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Ccrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and itle of certifier **RES000** 7/10/2009 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SINAL HOSPITAL OF BALTIMORE, 2401 W. BELVEDERE, BALTIMORE, MY MARTIN KUBIN, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Asken

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.



ORIGINAL

29c. License number

29d. Date signed (Month, Day, Year)

twaltsville Md. 20782

DHMH 17 Rev 1/2001

09-05297	
Bloss Battle	111

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Blos	s Battle, III		State of Maryland / Department of I  1- For State Certificate of I  Registrar		Reg.	No. 200	0 2212
Med	Physicia dical Exami	-	1. Decedent's Name (First, Middle,Last)  Bloss Battle, III		2. Date of Death Month D July 5, 2009	ay Year	3-Time of Beath 2115 hrs
			4a. Facility Name (if not institution, give street and number)  4b	. City, Town, or Location of Death		4c. County of Death	
	F		University Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Baltimore  If Under 1 Year   If Under 24Hrs	8 Date of Birth/		thplace (State or Foreign
	Funeral Director		220-04-6321 1XM 2F 50 Yrs.	Months Days Hours Min.	_ `	Co	untry)
	any	ŀ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	n			10d. Inside City Limits
7	and f show ince,	5	MD NA Baltimore	e			1 Yes 2 No
2	ith the Maryland 23a or 28a-f show any notified at once,	Director	10e. Street and Number 630 Scott Street	10f. Zip Code	10g.	Citizen of What Cou	ntry?
/	th th	- 1		21230 Decedent of Hispanic Origin? (Sp	ecify Yes or No-		ican Indian, Black,
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Funeral	1 Yes 2 X No	s, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc. Af 1	
	s after rral", c	盃	3 Widowed 4 Divorced If Yes, Give Year 1 Y	Yes 2X No specify: s Usual Occupation (Give kind of v	work done	Specify: Am 6	
	72 hour	eted		st of working life. DO NOT use reti		OD. Ritid of business/	. Idustry
	vithin ene.	Completed	12th Grade NA Home	e improvement 18.Mother's Name		Self-emp	loyed
	MD 21215-0036 at 2 should be filed within 7 atth and Mental Hygiene, m 27 is marked other than aumatic event, the Medica	Be Co	17. Father's Name (First, Middle, Last)  Bloss Battle, Jr.	18.Mother's Name		iden Surname) ~ Dixon	
	212 ould be d Ment s mark		19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing A	Address (Street and Number or F	Rural Route Number	er, City or Town, State	
	MD nd 2 sh alth an m 27 i		Pearl Battle-Sister   863 F	Herndon Court	Brookl	yn, MD 2	21225
	Baltimore, permit. Pages 1 ar Department of Hee important: If ite		1 X Yurial 2 Cremation 3 Removal from State Crematory or othe	or place) or Cem. 07-	I		
	ultim nit. Pa artmen sortant			me and Address of Facility Wy			
	Dep Dep injury		June la Uma ) 63	38 N. Gilmor	Street	Baltimor	e. MD2121
	Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.		t, shock, or heart	Approximate Interval Between Onset and Death	
1	`xaminer	Ì	Immediate Cause (Final disease or condition resulting in death)  a. Spontaneous intracer  Due to (or as a consequence of):	ebral hemorrhag	е		Death
		Ļ	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):				-
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated				
	ted 3 ansit	Exa	events resulting in death) Last Due to (or as a consequence of):				
	50,  Ite be executed hysician and burial - transit	edical	X UNPENDED 23a,27,perME,	g893 7/22/09 TT			
	Box 68760, or death certificate be the attending physicial red for use as the buri	/We	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the	3 \(\sum_{\text{Esto-is prome}}\)		23d. Date of delive	The state of the s
	BOX 6876  he death certificate  the attending phy hed for use as the I	iciar	past 12 months?  4 Pregnant at time of death 5 Oth	al death 3 Ectopic pregna er (Specify)	aricy	Month	Day Year
		Physician/M	1 Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the un	aderlying cause given in Part I	23e Did toba	acco use contribute to	the cause of death?
	P.O. Es that the digned by the detached	ξ	Part II. Other significant conditions contributing to death but not resulting in the on	denying cause given in react.			bably 4 Unknown
	rds, require been si	leted			24a. Was an		utopsy findings available completion of cause of
	eco he law ate has	ompleted			perform	ed? death?	
	Division of Vital Records, P.O. In or Attending Physician: The law requires that the safter death.  "I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact	Bec	25. Was case referred to medical examiner?	26.Place of Death (Check			
	of Vir ing Physical After this uneral dir	۴	1 V Yes 2 No Inpatient 2 ER/Outpatient			esidence 6 Other	er:
	on c ending ath. or: Aft	ţio	1 X Natural 5 Pending (Month, Day, Year)	1 Yes 2 No			
	VISION Att	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street	, factory, office building, etc.	28f. Location (Str or Town, Sta		ural Route Number, City
	Dispital hours a		4 Homicide determined (Specify)				
K	Division o  To the Hospital or Attending within 24 hours after death. To the Funeral Director: Aft completely filled in by the fune	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred one)  Wedical Examiner:On the basis of examination and/or investigation	s) and manner as stand place, and due to t	he cause(s)		
	, T <sub>0</sub> ivi	Me	and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (M	onth, Day, Year)
			aus C	O.C.M.E.		July 9, 2009	
	8 1		30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn St	treet, Baltimore, MD 2120	1		
	S	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature Signature	rkel			
	Regis	raf	TOLE O LOVO   COMO Jo. 19th		OCME	<del>.</del> .	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 6.25 AM Physician BROWN JAMES 28 05 0 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PALTIMORE BALTIMOR FUTURE CARE GOOW FMOCH 8. Date of Birth (Month, Day, Year Mar 28, 1 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Numbeunk | 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1**∑** M 2□ F 1944 65 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene.
Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural"; or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 ☐ No Baltimore Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21201 605 E. 35th Street Funeral unki 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. unk 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk unk 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) Be Department of Health and Merimontant: If item 27 1- any injury or consone. မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2700 N. Charles Street Baltimore, MD Future Care Homewood 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Funeral Service State Anatomy Board 655 W. Baltimore Street Wade 21201 Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau (Final disease or condition resulting in death) Physician metastati /Medical Due to (or as a consequence of): Examiner Ilmal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner mound law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Box 68760, Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. 9 Unknown 9 Unknown ned by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sign. 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has l page 2 s autopsy performed? After this certificate funeral director, pag 2 INO 25. Was case referred to medical examiner? To the Hospital or Attending Physician: 26. Place of Death (Check only one) Be Other: 4 Hursing Home 5 Residence 6 Other (Specify) 2 H0 2 ER/Outpatient 3 DOA 1 🖺 Yes 1 Inpatient P 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours af er dea h.

To the Funeral Director. A completely filled in by the fu 2 Accident dea h. 6 Could not be determined . Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P 31464 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Storte 308 BALTIMORT A HOYSHOOM 821 N 31. Date filed (Month, Day, Year) State JUL 1 3 2009 Registrar

Funera Directo

Physician / Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	•	For State Registrar		Olate of	iviai yiaii		ertifica		Death	nomai i	Reg. N	7 1 1	9	221	20
Physicia	เท	1. Decedent's Name (First,								2. Date of I	Death D	ay	Year	3. Time of D	
/Medic	al	Frank J 4a. Facility Name (If not ins			a family		Ab Ci	tu Taum ar	Location of Death			2009 c. County o	f Death	12:00	P .'''
Examin	er	407 Carro1			iber)		4D. CI		ederick			Frede			
uneral		5. Social Security Number	6. Sex	(	7. Age (In yrs.	last birtho		der 1 Year	If Under 24 Hrs.	8. Date of (Month,			9. Birthp	olace (State or	Foreign
rector		217-46-8940 Usual Residence of Decede		M 2□F	61	Yrs	Month	ns Days	Hours Min.	August	6,194	7 <u> </u> v	Vash:	ington,	D.C
at		10a. State 10b. C			10c. Cit	y, Town o	r Location						1	0d. Inside City	Limits
a-f st iffied	ctor	Maryland Fr	ederic	k			Fre	ederio	k					1½ Yes	≧ □ No
a or 28	Funeral Director	10e. Street and Number 407 Carro1	lton D	rive			10f.	Zip Code 21	701			Citizen of W ited		-	
ms 23	nera	11. Marital Status		12. Was Dece	dent Ever in U.	S.	13. Was De	cedent of H	ispanic Origin? (Sp n, Mexican, Puerto	pecify Yes or	No-		- American Indian,		
al", or iter	ğ	1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 🖾 Div		Armed For 1 ∐Yes If Yes, Giv Year or Da	2 ဩ No ′e			pecity Cuba 2⊠No	Specify:	o Rican, etc.)		Specify:	White,		
natur	Completed	15. De (Specify only	edent's Edu	cation e completed)		i (6	ecedent's U Give kind of	work done o	luring most of work	king	16b.	Kind of Bus	siness/In	dustry	
han "	d m	Elementary/Secondary (0		College (1	-4or 5+)	11	mber/(	T use retired	) -		Se	1f-Em	nlov	red	
nt, th		11. Father's Name (First, M	iddle Last)			114	mbci / v	Jarper	18. Mother's Nam	ne (First, Mide					
ked of	To Be	Henry Lee B							Doroth					ı	
mar	-	19a. Informant's Name/Rel	ationship (Ty	pe. Print)		19b. N	lailing Addr	ess (Street	and Number or Ru	ral Route Nu	mber, City	or Town, S	State, Zip	o Code)	
27 is er tra		Linda J. Tu	geon/S	Sister		1			e Drive,	Rockv					
Comportant; if them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Marical Examiner must be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Crem: 4 ☐ Donation 5 ☐ Ott		Removal from S	State Boy	Place of Demotery, yds I Irch C	isposition (/ crematory o res byt emeter	Vame of or other place cerian Y	July 20		Во	yds,	Mary	land	
Importa any Inju		21. Signature of Funeral Se	rvice Licens		1498		22. Name	and Addre	ss of Facility Rob Inc. 30 Mary 1an	ert A. 0 West	Pum O <sup>Mon</sup>	phrey tgome	Fun ry A	eral Ho venue	ome/
rsician ledical aminer	iner	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Chronic Obstructive Pulmonary Disease  Chronic Obstructive Pulmonary Disease  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to lor as a consequence of):  Due to lor as a consequence of):													veen leath
ng physician and as the burial-transit	Due to (or as a consequence of):  cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  d.														
ne attendir ed for use	Physician/Med	FFEMALE:   23b. Was decedent pregnant   1													'ear
signed I	by	Part II. Other significant co	nditions co	ntributing to de	eath but not res	ulting in t	ne underlyin	ng cause giv	en in Part I.	1				the cause of de obably 4 □ U	
ate has bee page 2 shou	Completed							<u>-</u>		l p	/as an utopsy erformed?	? p	rior to co leath?	opsy findings a completion of ca	available ause of
ertific ctor,	Be (	25. Was case referred to mexaminer?	}-						26. Place of Dea	th (Check or	ly one)				
this o	ပ္	1 ☐ Yes 2 🔯 No			npatient 2				4 🗆 Nursing ri					ify)	
ector: After by the funers	Certification:	2 ☐ Accident i 3 ☐ Suicide 6 ☐ 6	Pending nvestigation Could not be letermined	28e. Place	of Injury th, Day, Year) of Injury - At hong, etc. (Special	28b. Tir Inji ome, farm	iry M		yat k? Yes 2 ∐ No		28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number,				
Funeral Dir	edical Cert	29a. Certifier 1 ☒ Ce	rtifying Phy dical Exami	rsician: To the iner: On the b	best of my knoasis of examina	owledge,	death occur or investiga	red at the ti	me, date and place opinion, death occu	e, and due to	the cause	e(s) and ma	anner as and due t	stated. to the cause(s)	)
To the comple	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and do and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Mor														
		30. Name and address of p						enue,	Suite 20	4, Fre	deri	ck, M	ary1	and 217	02
Sta Registr		31. Date filed (Month, Day,	Year) 1 3 20(	32. R	legistrar's Signa	ature A.	park	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9<sup>Day</sup> **Physician** 2009 James Lee Bethea Ju<sub>1</sub>y 5:30 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Bedford Court Nursing Home Silver Spring If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex Age (In yrs. last birthday) Funeral 1 XM 2□ F Months Days Hours Min. Director 579-38-1016 84 December 5, 1924 Washington, D.C. Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 15400 Bassett Lane #3E United States filed within 72 hours after death 12. Was Decedent Ever in U.S.
Armed Forces?

1 XYes 2 □ No
If Yes, Give
Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. Specify: White 2 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Library of Congress at of Health and Mental Hygiene. If item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Librarian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be pe ပ Lonnie James Bethea Annie Lucile Hutchison Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15400 Bassett Lane #3E, Silver Spring, Maryland 20906 Bertha A. Bethea / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)  $\begin{array}{ccc} \text{Date} \\ \text{Montgomery Crematorium} \end{array} \quad \begin{array}{c} \text{Date} \\ \text{July 12,} \\ 2009 \end{array}$ 20a. Method of Disposition 20c. Location - City or Town, State 6 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of Important; If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. M01360 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic Colon Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Electronic rhy of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed burial-transit and Due to (or as a consequence of) Box 68760, physician at the burial Physician/Medical The law requires that the death certificate use as been signed by the attending should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.O. □Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ Atrial Fibrillation 1 Tyes 2 No 3 Probably 4 N Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 TXNo 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D45285 July 9, 2009

12

State Registrar

JUL 1 3 2009

Wilkerson Ninala,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. 344 University Blvd. W, Suite 113 Silver Spring, Maryland 20901

Months

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Davs

BALTIMORE

Hours

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

Jr. FH MD 21224

Approximate Interval Between Onset and Death

Day

Year

1 Nes 2 No

Ĭťaly

4c. County of Death

8. Date of Birth (Month, Day, Year)

0-27-1919

04 PM

**Physician** /Medical Examiner

1 - For State Registrar

JOHNS

10a State

5. Social Security Number

218-80-4821 Usual Residence of Decedent

4a. Facility Name (If not institution, give street and number)

6. Sex

1 □ M 2 🕱 F

HOPKINS

10h. County

BAMVIEW MEDICAL CENTER

89

7. Age (In yrs. last birthday)

**Funeral** Director

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Maryland 21215-0036

the Maryland 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, "tw Medical Examination and the mailined at Director death 1 Funeral 72 hours after þ Completed permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturany injury or other traumatic event and page. Be ပ

**Physician** /Medical **Examiner** 

Examiner

Physician/Medical

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Completed

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Certification: To

MOSTAFA

31. Date filed (Month, Day, Year)

JUL 1 3 2009

sician and burial-transit attending physician for use as the buria signed by the a d be detached for cate has been signated by page 2 should b certificate this

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, & P.O. | Records, Division of Vital funeral director, After t death. ours after death.

neral Director: A
filled in by the fi within 24 hours completely the

10c. City, Town or Location Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21224 22 S. Highland Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc Specify: White 1 ☐ Never Married 2 X Married 1 ☐ Yes 2K No Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) In own home Homemaker 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Vittoria Ranieri Pietro Froio 19a. Informant's Name/Relationship (Type. Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21224 236 S. Highland Ave., Baltimore, Maryland Petrucci Victoria 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/11/2009 Baltimore, MD 4□Donation 5 2 Other (Specify) entomb. Oaklawn 22. Name and Address of Facility Joseph N. Zannino 263 S. Conkling St., Baltimore, 21. Signature of Funeral Service Licensee 23a. P.M. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final RENAL FAILUEE disease or condition resulting in death) Due to (or as a consequence of): CHRONIC KIDNET Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectonic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 2 No 3 Probably 4 Unknown 1 🔲 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖪 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State

Registrar

4940

32. Registrar's Sigrature

EMSTERN PUENUE

BAUTIMORE

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 2009 6:10 PM KCASSON DENNIS CLIFTON TULY 06 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner UNIVERSITY OF MARYLAND timore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 6/20/2009 Maryland **Director** NONE Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City, Town or Location r than "natural", or items 23a or 28a-f show Baltimore 1XYes 2 No Director MND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21216 USA Funeral rair 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify <u>}</u> Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, If a more. Elementary/Secondary (0-12) College (1-4or 5+) IA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mial မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mia Clifton fax Rd, Baltimore MD 21216 1 mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (5 3 Removal from State Ardent Crematory 7-10-2009 Hanover, Maryland 5 Other (Specify) 22. Name and Address of Facility Charisse N. Woods Funeral Service 21. Signature of Funeral Service Licensee MO1358 3307 mondawmin Ave. Baltimore MDZ1216 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** INTESTINAL PERFORATION /Medical Due to (or as a consequence of): Examiner XTREME Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Exami Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 □No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) npatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide

Hospital or Attending PhysIclan: The law requires that the death certificate be executed burlal-tran P.O. Box 68760, certificate has been signed by the attending physician rector, page 2 should be detached for use as the burla Division of Vital Records, director. 24 hours after death.

Funeral Director: After this letely filled in by the funeral di within 24 hou

To the Fune

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

22225

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 29c. License number

2009

ID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SVITE 110 BALTIMORE MD 298 GREENE ST KAVITHA KONDURU 2. Registrar's Signature

State Registrar

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 **Physician** 1E66 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE VENUE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🗹 F Director 1926 PENNSYLVANIA 8, Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show 1 ¥Yes 2 No Directo MARYLAND BALTIMORE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Completed by Specify: BLACK 3 Widowed 4 ☐ Divorced "natural", Ith and Mental Hygiene.
7 Is marked other than "natur traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CAN IOTH CRADE COMPANS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) かんしいけんしん Be MARY ဥ UNKNOWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a 3710 WILDOR AYE, WINDSOR MILL, MD QIQYY RALPH SIMPSON (NEPHEL. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If its any Injury or o once. 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State CREMATORY 07/13/2009 BALTIMORE, MARYLANT 4 ☐ Donation \_ 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee IN JR. FUNERAL HOME SUSEPH H. BROW AVE, BALTIMORE, MD 21217 2140 N. FULTON 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 2144 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) g physician and as the burial-transit or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Physician/Medical attending ph IF FFMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🔲 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐Yes 2 ☐ No After this certificate has been signed by the funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 1 □Yes 2 DNo 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 √0 Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital Medical 🕮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 2000

82. Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** d:095W Mila Aurielle Cottman /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Glen Burnie Ctr Baltimore Washington Med 8. Date of Birth (Month, Day, Year) June 27, 2009 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 45<sup>Min.</sup> Months Days Hours 1 □ M 2 🛱 F Maryland infant Director Usual Residence of Decedent 10d Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County 10a, State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2♥ No Director MD Anne Arundel Millersville 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 21108 USA 600 Millwright Ct #43 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 X Never Married 2 Married ٩. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify Specify: black þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygient Important: If item 27 is marked other than any injury or other traumetic. Elementary/Secondary (0-12) College (1-4or 5+) infant infant infant infant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Trevor A. Cottman Sheritria E. Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sheritria E. Johnson/mother 600 Millwright Ct #43 Millersville, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) in state Signature of Funeral Service Licensee Ronald S. Wade, 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street rector Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** treive /Medical Due to (or as a consequence 30 mins Examiner 1745 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent Examine and Due to (or as a consequence of): attending physician certificate be Physician/Medical the as IF FEMALE: nse yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month for Day 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 No certificate 1 □ Yes 25. Was case referred to medical examiner?
1 2 Yes 2 □ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 □ No 1 ☐ Inpatient 2 ☐ R/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 ☐ Homicide

Box 68760, P.O. Division of Vital Records, e Hospital or Attending Physician: 24 hours after death.
8 Funeral Director: After this certificaletely filled in by the funeral director, p. within 2 To the F the 0

> State Registrar

Medical

29a. Certifier

29b. Signature

and title of certifier

3. Registrar's Signature 31. Date filed (Month, Day, Year) JUL 13

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

3 R 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 750 M 2009 Ramon Cortez 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Numbernk 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Hours unk Oct 23, 58 1950 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2√ No Washington Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 18601 Roxbury Road 21742 USA unk 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. unk 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: mexican 1**X**Yes 2□No white 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 251 E. Antietam Street Hagerstown, MD Washington County Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☑ Other (Specify) in state 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Signiture of Euneral Service Licensee Ronald S - Wad 21201 Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to or as a consequence of) Sequentially list conditions, Due to for as a consequence off.

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

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Director

Funeral

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Marical Examinating is actived.

Baltimore, Maryland 21215-0036

Examiner To the Hospital or Attending PhysIcian: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Physician/Medical Be Completed by Certification: To

Division of Vital Records, P.O. Box 68760

cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	23c. If yes, outcome of pregnancy  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy  4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions o	Shiributing to death but not resulting in the encomying sease given in the encomy	Did tobacco use contribute to the cause of death?  1 □ Yes 2 □ No 3 □ Probably 4 ☑ Unknown
		Was an autopsy performed? // yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical	26. Place of Death (Check of	only one)
examiner? 1 ☐ Yes 2 🕱 No	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5	Residence 6 Other (Specify)
27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year) Injury Work?	ribe how injury occurred

6 ☐ Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

**JUL 13** 

3 ☐ Suicide

29a. Certifier

4 THomicide

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

32/ Registrar's Signature

State Registrar

Medical

09-05400 William Davis, Jr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 22132

		For State	tato of many	(	Certific	ate of I	Death				g. No.	40	
Physiciar Medical Examin	n/ 1	egistrar . Decedent's Name (First, Mid		liam	Dav	is,			Jt	Date of Deat Month LIV 9, 200	Day )9	Year	3. Time of Death 1942 hrs
	4	a. Facility Name (if not institut Johns Hopkins Hosp		mber)		41	o. City, Town, or L Baltimore	ocation of				nty of Dea	
Funeral Director	5	5. Social Security Number 215–72–2362	6. Sex	7. Age (In	yrs. last bir	thday) Yrs.	If Under 1 Year Months Days	If Under Hours		Date of Bir 3-5-19		YYY) g. B	sirthplace (State or Foreign Country) S.C.
	- 1-	Usual Residence of Decedent			City, Town	an Looptic							10d. Inside City Limits
ow any		0a. State 10b. Count	N/A		Baltir		,,,,						1 X Yes 2 No
S & uryland uryland at once	Director	10e. Street and Number			_		10f. Zip Code			1	0g. Citizen o		ountry?
vith the Maryla s 23a or 28a-f		820 S. Caton					21229				USF		erican Indian, Black,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status	12. Was Dec Armed F	orces?		13. Was	Decedent of Hisp es, specify Cuban	panic Origi , <b>Me</b> xican,	in? (Speci Puerto Ric	an, etc.)		White, etc.	
ter dea			1 Yes Divorced or Dates:	<sup>2</sup> XX			Yes 2 X No					cifyBla	
ours af atural	g b	15. Decedent's Education (S	pecify only highest gra	de complet	ed) 16a	. Decedent	t's Usual Occupatiost of working life.	ion (Give k DO NOT u	ind of work use retired	( done )	16b. Kind	of Busines	ss/Industry
36 in 72 h han "n	Completed	Elementary/Secondary (0-1 12th grade		1-4 or 5+) yrs +		Dis	sabled				D:	isabl	ed
5-0036 lled within 7 Hygiene. I other than	8	17. Father's Name (First, Midd						18.Mother's	s Name (F		Maiden Sur		
1215 be file ental H orked o	å	Willian Davi	s, Sr		- 11	Oh Mailing	Address (Stree	Jes	sie M		oodard		tate, Zip Code)
D 21 should I and Mer 7 is mar	٩	19a. Informant's Name/Relation Jessie Mae D		r			N. Chest				alto,	MD 2	21213
e, MD 1 and 2 sho Health and item 27 is	ł	20a. Method of Disposition			20b. Place crem	of Dispos atory or ot	ition (Name of cer her place)	metery,		Date			y or Town, State
MOF Pages lent of unt: If		1 Burial 2 Crema 4 Donation 5 Other	Specify:	Irom State	King		orial Pa			7-2009	Ran		stown, MD
Baltimore, permit. Pages I as Department of Her Important: If ite	İ	21. Signature of Funeral Serv	rice Licensee			22. 1	Name and Address						21202
Physician	$\dashv$	23a. Part I. Enter the disease	, or complications that	caused the	death. Do	not enter t	he mode of dying	, such as c	cardiac or r	espiratory a	rrest, shock,	or heart	Approximate Interval Between Onset and
Medical .aminer		failure. List only one ca Immediate Cause (Final dise	ase a. Hypert	ensiv	ve at	heros	<u>clerotic</u>	cardi	iovas	<u>cular</u>	disea	ıse	Death
.ammei		or condition resulting in deat	h) Due to (or as	a consequ	ence of):								
	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequ	ence of):								
	Examine	cause. Enter Underlying Ca (Disease or injury that initiate events resulting in death) La	ed C.	a consequ	ience of):								
760, Toate be executed s physician and the burial - transit			d	23a	. 27 . P	TT pe	r ME g89	3 7/3	30/09	TT			
60, ate be ex physician	Medical	IF FEMALE:	AMENDED	s, outcome							23d.	Date of de	•
(ecords, P.O. Box 68760, The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial - transi		23b. Was decedent pregnant past 12 months?	in the 1 Live	e birth gnant at tir		2 F		Ectop	ic pregnan	ісу	M	lonth	Day Year
Box 687 E death certific the attending 1	ysician/	1 Yes 2 No 9	Unknown g Uni	known		0 0	other (Specify)						il and a fide the
5.0. Bc that the des ned by the s	by Phy	Part II. Other significant co	nditions contributing	to death b	ut not resu	Iting in the	underlying cause	given in P	Part I.	1			te to the cause of death?  Probably 4  Unknown
of Vital Records, P.C ing Physician: The law requires that After this certificate has been signed tuneral director, page 2 should be det	ted b	Morbid	obesity							24a. W		24b. W€	ere autopsy findings available or to completion of cause of
Cord law rec has bee	ompleted									pe	itopsy erformed? es 2 No	dea	ath?  Yes 2 No
DZ [	Co	25. Was case referred to me	edical				26.Pla	ce of Deat	th (Check o				
Vita  ysician this cer	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatien		R/Outpatie		Other 4		g Home 5	Residen		Other:
ling Ph After	no.	27. Manner of Death  1 X Natural 5	28a. Di (Mo	ate of Injury onth, Day,Yea		8b. Time o		njury at Wo Yes 2		200. Descri	De now injui	y coodinoc	
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Directors: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detact	Certification:	2 Accident 3 Suicide 6	Investigation 28e. F		ry - At hom	e, farm, st	reet, factory, office	e building,	etc.		on (Street an	d Number	or Rural Route Number, City
Hospi 4 hou Funer ely fil	al Cer	4 Homicide  29a. Certifier (Check only)  Certifyi	ng Physician: To the 1 Examiner: On the bar		knowledge	, death occ	curred at the time,	date and p	place, and occurred a	due to the out the time, of	cause(s) and	I manner a	as stated. e to the cause(s)
To the within 2 To the Complet	Medical	one) 2 Medica  29b. Signature and title of c	andmann	er stated.				ense numb			29d. D	ate signe	d (Month, Day, Year)
	-	Wille !	Grasself,	M	9	0-1	0.0	C.M.E.			July	10, 200	9
OCME		30. Name and address of p Melissa Brassell,		cause of de Medical	eatn (Item 2 Examine	:эа) er 111	Penn Street	, Baltimo	ore, MD	21201			
V	Stat	31. Date filed (Month, Day,	Year) 32	. Registrar									
Regi		T JUL	1 12 20mm l	ann	- J	ORUĞIN	ares						
DHMH 17 Rev 1	/2001		7.		•	ORIGIN	NAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death Month 3. Time of Death cedent's Name (First, Middle, Last) **Physician** 02:30A M 10 er /Medical 4c. County Name (If not in ition, give street and num Examiner altimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Wonth, Day, 9. Birthplace (State or Foreign 6. Sex 5. Social Security Numb 7. Age (In yrs **Funeral** Days Months 1 □ M 2 🗷 F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer must be notified at once. 10d. Inside City Limits 10b. County Town or Location 1XYes 2 ☐ No **Funeral Director** It more 10g. Citizen of What Country? 10f. Zip Code 14. Race - American Indian Black, White, etc.\_\_ 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify Completed by 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) (Sacondate (0-12) College (1 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DefNOT use retired) College (1-4or 5+) 18 Mother's Name (First, Middle, Ma. Be ပ 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 Removal from State □ Donation 5 □ Other (Specify) Signature of Funeral Service Licensee Approximate Interval Between Par 1. Enter ) e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, tailure. List only one cause on each line. shock, or heart failure. Onset and Death mmediate Cause (Final licease or condition esulting in death) ~ 2 days **Physician** Bacteremia /Medical Due to (or as a consequence of): Examiner Superior Vena Cava Syndrome unknown Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed unknown Small cell lung cancer Due to (or as a consequence of) Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □Yes 2 ☑No 3 Ectopic pregnancy Year Month 5 ☐ Other (specify) P.O. cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? autopsy perform After this certificate 2 🗆 No 1 ☐ Yes 8 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 No death. 2 Accident within 24 hours after death To the Funeral Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD AT2438946 July, 10, 2009 address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Year)

1 3 2000

Quianzon, MD

32. Registrar's S

Union Memorial Hospital, MD

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After

> State Registrar

Medical

6 Could not be determined

M.D.

Year)

30. Name and add(ess of person who completed cause of death (Rem 33a) (Type, Print)

2401 Research Blvd.

32. Registrar's Signature

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only

John Kelly,

31. Date filed (Month, Day,

29b. Signature and title of certifier

#340

🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D06349

Rockville, Maryland 20850

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

July 9, 2009

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1:30 AM Month 7 09 amonas Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Timonium 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth or Foreign 66 Days Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 Yes 2 □ No Funeral Director more 10f, Zip Code 10g. Citizen of What Country? and Number 21218 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1X Never Married 2 ☐ Married 1 □Yes 2 No ģ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life., DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) unknown ၉ 19b. Mailing Address (Street and Number or Rural Route No 19a. Informant's Name/Relationship (Type. Print) Ullin 20a. Method of Disposition 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter if shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any solid list cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

State Registrar

Medical

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Pages 1

Department of Important: If It any Injury or one

**Physician** 

/Medical

Examiner

physician and the burial-transit

Item 27 Is marked other than "natural", or items 23a or 28a-f shot other traumatic event, I're Medical Examinar must be notified at

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Daţe signęd (Month, Day, Year)

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29b. Signature and title of certifier

29a Certifier

State of Maryland / Department of Health and Mental Hygiene- UU 9 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 2009 June 22, 11:01 PM Diane M. Exter /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Worcester 12129 Dutch Harbor Lane Berlin | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year May 20, 19 9. Birthptace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 ☐ M 21以 F 1943 Director 217-40-3616 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County I7 is marked other than "neturel", or Items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Directo Worcester Berlin 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21811 12129 Dutch Harbor Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. e filed within 72 hours after of Hygiene.
other than "neturel", or Iter 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No tf Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) food industry waitress permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any liquy or other traumatic event 908. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mari Louise Barbour Frederick Bernard Wildberger ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12129 Dutch Harbor Lane Berline, MD Jerry Exter/spouse 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ 9ther (Specify) 21. Signature of Funeral Service Licensee Ronald So Wade State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Chronic Myelomono cyfic **Physician** 70013 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospital or Attending Physicien: After this certific funeral director, Be 25. Was case referred to medicat 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending after death. Director: Af 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and titte of certifier ant July 6, 2009 030690 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) 100 E. Gerrall St. Solisbury, MD, E MARTIN MO James parker 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 132009 Registrar

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	Jr. State of Maryland / Department of Health and M 1- For State Certificate of Death	Mental Hygiene	Reg. No. 201	19 2213
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last)  Arnold Aaron Foster, Jr	2. Date of Month July 8,	Dav Year	3. Time of Death 1245 hrs
(	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Local 3906 Fairfax Road  Baltimore	ation of Death	4c. County of Death	
Funeral			of Birth (MM/DD/YYYY) 9. Bir Foreig	thplace (State or
Director	214-25-9046   1X M 2 F   21 Yrs.   Months Days   F	Hours   Min.   12-2		untry) MD
>	Usual Residence of Decedent  10a. State 10b. County 110c. City. Town or Location			10d. Inside City Limits
ом ану				1 X Yes 2 No
Aaryland 28a-f show 1 at once ector	MD N/A Baltimore  10e. Street and Number 10f. Zip Code		10g. Citizen of What Cou	
the Maryland a or 28a-f sh tified at once Director	1807 N. Collington Avenue 21213		USA	
with the 1s 23a pe noti	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispani			ican Indian, Black,
er death with or items 23 must be no Funeral	1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Me		R	lack
s after mal", o niner	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No sp		Specify:	
hours frantui fed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (during most of working life. DO		16b. Kind of Business	
5-0036 ed within 72 hours tygiene. other than "natu the Medical Exan	10th grade N/A Maintenance		Program	
5-00 ed wid tygien other Con	Tr. Fathor S Trains (Fine) Timedre, East)	Mother's Name (First, Mid		
121 I be fill ental P arked vent, I	Indica in 1920a, 11	ngela Johnso	version of the second	Zin Onda)
MD 21215-0036 of 2 should be filed within 7 lith and Mental Hygiene. In 27 is marked other than numatic event, the Medica To Be Comple	19a. Informant's Name/Relationship (Type, Print)  Angela Johnson –Mother  19b. Mailing Address (Street and 1807 N. Colling address)			e, MD 21202
and 2 Jealth Sealth term 2	20a. Method of Disposition 20b. Place of Disposition (Name of cemete	ery, Date	20c. Location - City o	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	1 XX Burial 2 Cremation 3 Removal from State Western Star Cemete	ery 7-16-09	9   Catonsvi	lle, MD
Baltin Permit. Pa Departmet Importan	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of I	Facility March	East F/H	
Dep Tiliji		orth AVenue		
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, suc failure. List only one cause on each line.	ch as cardiac or respirator	ry arrest, shock, or heart	Approximate Interval Between Onset and
/Medical xaminer	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):			Death
	h			
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
ted 1 nnsit Examiner	(Disease or injury that initiated events resulting in death) Last			
to, e be executed ysician and burial - transit	d			
0, s be execut sician and burial - tra	UNPENDED		Leave But duties	
876 tificate ng phy ss the l	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	Ectopic pregnancy	23d. Date of delive	ry Day Year
Box 6876( e death certificate the attending phy ed for use as the b hysician/Me	past 12 months?  4 Pregnant at time of death 5 Other (Specify)		6	
h. Box 6876 the death certificate you the attending phy ched for use as the Physician/M	Yes 2 No 9 Unknown g Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	n in Part I 23e	Did tobacco use contribute t	o the cause of death?
P.O. s that t	Falt II. Other Significant Conditions Complicating to death but not resulting in the shooting gester given	1		obably 4 Unknown
Records, The law requires ficate has been sig				autopsy findings available
COr law r s has b e 2 sh mple	() <del></del>		performed? death?	
i: The tifficate or, page	25. Was case referred to medical 26.Place of	Death (Check only one)	Yes 2 No 1 🗸	165 2 140
Vital ysician ysician directo		ner.  Nursing Home	5 Residence 6 🗸 Oth	er: Scene
of ng Ph	27. Manner of Death .28a. Date of Injury (Morth. Day, Year) 28b. Time of Injury 28c. Injury a	Subject	cribe how injury occurred	
Sion titendi death ctor: 2	2 Accident Investigation Jul 8, 2009 1232 hrs	2 <b>V</b> No		D. I. N Other
Division of Vital Records, P.O. spital or Attending Physician: The law requires that th rours after death neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detach Certification: To Be Completed by P	3 Suicide 6 Could not be determined (Specify) Vacant Rowhouse		ition (Street and Number or F own, State) irfax Road , Baltimore , M	
ospita   hours   unera   Jy fille	4 Momicide determined (Specify) Vacant Rowhouse  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date in the control of the			
Division of Vital Records, P.O. Box 6876.  To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the I Medical Certification: To Be Completed by Physician/IM.	(Check only one) 2 Medical Ex iner: On the basis of examination and/or investigation, in my opinion, de and manner stated.	eath occurred at the time,	, date and place, and due to	the cause(s)
Σ	29b. Signature and title of certifier 29c. License no	umber	29d. Date signed (A	Ionth, Day,Year)
3	O.C.M.I	E.	July 9, 2009	
OCME	30. Name and addres of pers in who completed cause of death (tem 23a)  Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, B	Baltimore, MD 2120	)1	
State	24 Date Standard Constitutes	,		
Registrar	40.55 c			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Month 6:35 PM 2009 CLARA FOWLER 07 10 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE HUSPITAL, MD GOOD SAMARITAN If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 1 □ M 2 🖾 F 73 Yrs 213-30-2631 12-12-1935 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County Yes 2 □ No Md Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number och Raven Blvd 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Black Specify: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last Sinclair 19b. Mailing Address (Street and Number or Rural oute Number, City or Town, State, Zip Code) Informant's Name/Belationship Daughter 52021 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service in ensee 22 Name and Address of Facility Vauton Coreene Funeral Services 4905 Park Boad Baltima re Maribid 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final TWO DAYS SEPTIC UROSEPSIS SHOCK disease or condition resulting in death) Due to (or as a consequence of): URINARY TRACT INFECTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) SEVERE RIGHT SIDED HEART Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 ☒ No Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ARTERY DISEASE CORONARY 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy perform 2. No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

be executed

requires that the death certificate

Box 68760.

P.O.

Records.

Division of Vital

Physician:

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

Be

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygelner. In Department of Health and Mental Hygelner. In Department of Health and Mental Hygelner (Inportant: It if ferm 27 is a marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Inc. Medical Examinator must be notified as injury or other traumatic event, Inc. Medical Examinator must be notified.

Baltimore, Maryland 21215-0036

Examine

and burial-tra attending physician the as asn. for signed by the a d be detached for page 2 should has certificate funeral director, this ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After the After t

Physician/Medical \$ Completed Be Certification: To the filled in by

Medical the within 7 State

remall at 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SAMEER CHAUDHARI 31. Date filed (Month, Day, Year)

JUL 1 3 2009 Registrar

29a. Certifier

(Check only

29b. Signature and title of certifier

1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 1 X Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

28b. Time of Injury

and manner stated

RESIDENT PHYSICIAN

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28c. Injury at Work?

29c. License numbe RES-000

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year) 2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

SAMARITAN HOSPITAL, SOOI LOCH RAVEN BLVD BALTIMORE, MD.

21239

6000 32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19 hat Best Mary (1888) De 3 / 1990 in the Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 3:00 PM BARBARA Julu FRIEDBERG 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner City SINAI Hospital OF Baltimore Raltimore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Funeral 1 □ M 2 🕇 F Months Days Hours 133-26-7965 Director 74 07/31/1934 Usual Residence of Decedent with the Maryland 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 No Director N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 6300 RED CEDAR PLACE, #406 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc 1 Never Married 2 Married 21215-0036 1 □Yes 2 X No WHITE \$ Specify: filed within 72 hours 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If item 27 is marked other the any injury or other traumatic event, if all ones. LECTURER WEIGHT WATCHERS Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JACK NUCHOW ည ROSE LABARBARA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) STEVE FRIEDBERG / SON 104 BIRCH DRIVE DOWINGTOWN PA 19335 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) HAR SINAI 07/10/2009 OWINGS MILLS, MD 22. Name and Address of Facility 21. Signature of Funeral Service License SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** exacerbation 7 day /Medical Due to (or as a consequence of): Examiner Dulmonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by disease 1 res 2 No 3 Probably 4 Unknown Colonary COPD 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ■No 24a. Was an autopsy 2 **1** No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral dir Certification: To 27. Manney of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide e Funeral 1 Letifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hounded to the total of the fune completely file Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

ARBARA

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FRIEDISERG

SS

DHMH 17 Rev 1/2001

of Baltimore, 2401 W. Belvedere, Baltimore MD

Hospital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vang

31. Date filed (Month, Day

Year)

**JUL 13** 

		amend #18,19acb,20a	State of Mary	yland / Dep	artment of	Tealth and N	lental Hy	giene	_
		for State Registrar		Ce	rtificate of	Death		Reg. No. 2	2214
Dhuri		1. Decedent's Name (First, Middle, Last)					2. Date of De		3. Time of Death
Physic /Med		James Fusco					07	06 09	
Exam	iner	4a Facility Name (If not institution, give s	at the L	AKE	Sal	or Location of Death			omico
Funera Directo		Social Security Number     6. Sex	7. Age (	n yrs. last birthday)	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Sept 10	av. Year)   C	thplace <i>(State</i> or Foreign ountry) nsylvania
put		Usual Residence of Decedent  10a. State 10b. County	10	Oc. City, Town or Lo	ocation				10d. Inside City Limits
Aaryla f sho ed at	jo	MD Wicomico		Fruitla					1 □ Yes 2√∑No
the N 28a- notifi	rec	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
h with	al D	311 S. Camden Ave	nue			21826		USA	
if e, INIALY INITIAL CILID-UUDO s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, In a Marical Evaminer must be notified at	y Funeral Director	1 Never Married 2 Married	12. Was Decedent Eve Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give		Was Decedent of If Yes, specify Cub	Hispanic Origin? (Spoan, Mexican, Puerto	pecify Yes or No Rican, etc.)	14. Race - Am Black, Whi	te, etc.
hours ural"	sd by	3 ☐ Widowed 4 ☒ Divorced	Year or Dates:	16a Dece	edent's Usual Occu	nation		16b. Kind of Business	
Lafficial CICID-0030 2 should be filed within 72 hours aft and Mentat Hygiene. Is marked other than "natural", or aumatic event, the Modical Eventa	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 1 2	Completed)  College (1-4or 5+)	(Give	e kind of work done DO NOT use retire	during most of worked)	king	automotive	•
filed Hyginather Hyginather	Be C	17. Father's Name (First, Middle, Last)			<u> </u>		e (First, Middle	e, Maiden Surname)	·un
Maryland Z 1 Z d 2 should be filed withi th and Mental Hygiene. 77 is marked other than traumatic event, Inc. M.	10 B	Dominick Fusco				Maria	Mancin	ıi	
lary 2 shou 2 shou and N is ma		19a. Informant's Name/Relationship (Ty						per, City or Town, State,	
Dallinore, IN permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tr		Linda Ellen Fusco  20a. Method of Disposition  1 Burial 2XX cremation 3 F  4 Donation 5 X The Conference Signature of Survive License	in state	Metro Cr	rematory	Inc. 7/14	/2009 1 655 W		Maryland Street
		23a. Part   Enter the disease, or complished, or heart failure. List only or	ications that caused the cause on each line.					. •	Approximate Interval Between Onset and Death
tificate be executed  Examine  g physician and as the burial-transit	Examiner	Sequentially list conditions, if any, and if any, and if any, and if any, and if any, and if any, and if any, and if any, and any, and if any, and if any, and if any, and if any, and if any, and if any, and if any, and if any, and if any, and if any, and if any, and if any, and if any, and if any, and if any, any, and if any, any, and if any, any, and if any, any, and any, any, any, any, any, any, any, any,	o	consequence of consequence of):					
ath cer	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1  Live birth 2 4  Pregnant at ti 9  Unknown	Fetal death 3	☐ Ectopic pregnar	ncy		23d. Date of d Month	elivery Day Year
us, F.C. luires that the den signed by the	þ	Part II. Other significant conditions con	ntributing to death but	not resulting in the	underlying cause g	iven in Part I.		tobacco use contribute Res 2 □ No 3 □	to the cause of death?  Probably 4  Unknow
he law requires ti e has been signe ge 2 should be c	Completed						24a. Was auto perl 1 □Yes	formed3 death	
T ⊥	Be (	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only	on-)	
clan: Tr clan: Tr ertificate		1 ☐ Yes 2 ☐ No  27. Manner of eath	lospital: 1 ☐ Inpatient 28a. Date of Injury	2 ☐ ER/Outpation	ent 3 🗆 DOA		lome 5 ☐ Res	sidence 6 Other (S <sub>k</sub>	pecify) HOSPICI
Physician: The law requir this certificate has been s al director, page 2 should	2		(Month, Day,		Wo	uryat ork? □Yes 2□No			
On OT VITA  ling Physician:  After this certific funeral director, I	ertification: To	Natural 5 Pending investigation 3 Suicide 4 Homicide 5 determined	28e. Place of Injury building, etc.	- At home, farm, s (Specify)	treet, factory, office			(Street and Number or sown, State)	Rural Route Number,
On OT VITA  ling Physician:  After this certific funeral director, I	Certification:	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certiffer  1 Sertifying Phy	28e. Place of Injury building, etc.	my knowledge, dea	ath occurred at the investigation, in my	time, date and place	City or To e, and due to th urred at the time	own, State) he cause(s) and manner e, date and place, and d	as stated. ue to the cause(s)
On OT VITA  ling Physician:  After this certific funeral director, I	Medical Certification: To	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only 2 Medical Exami	28e. Place of Injury building, etc.	my knowledge, dea	ath occurred at the investigation, in my	time, date and place	City or To e, and due to th urred at the time	own, State) he cause(s) and manner e, date and place, and d	as stated. ue to the cause(s)
Or VILA Physician: r this certific ral director, I	Certification:	1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier	28e. Place of Injury building, etc.	my knowledge, dea	ath occurred at the investigation, in my	time, date and place	City or To e, and due to th urred at the time	own, State) he cause(s) and manner e, date and place, and d	as stated. ue to the cause(s)
JII OI VIIGA ling Physician:  After this certific funeral director,	Certification:	1 Natural 2 Accident 3 Sulcide 4 Homicide  29a. Certifier (Check only one)  1 Pending Investigation 6 Could not be determined	28e. Place of Injury building, etc.	my knowledge, dea	ath occurred at the investigation, in my	time, date and place	City or To e, and due to th urred at the time	bwn, State)  The cause(s) and manner  The date and place, and d	as stated. ue to the cause(s)

4a. Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death Examiner Clinton

Vear | If Under 24 Hrs.

Min. Southern Maryland Hospital 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 € M 2 □ F Davs Months Hours Min. Yrs. 58 Director 577-60**-**9897 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Medical Examinal must be notified an once. Director MD Prince George's Clinton 10e. Street and Number 10f. Zip Code 20735 9211 Stuart Lane Funeral unk 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: ģ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unk 0 Stock Clerk 17. Father's Name (First, Middle, Last) unk. ٩ Clifton Fridie, Sr 19a. L'orraine Rentinatie (79 p. Print) 19a. L'orraine Rentinatie (79 p. Print) Southern Maryland Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/27/2009 4□Donation 5₺ Qther (Specify) in state | Lee's Crematory 21. Signature of Lynera Service Licensee Ronald S. Wade, Director m Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner He a dequentially flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) /sician and Due to (or as a consequence of) ing physician as the burial P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records. Be Completed by STIVE on 98 25. Was case referred to medical examiner? 1∐Yes 2ÆNo completely filled in by the funeral dir Medical Certification: To 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 24 hours after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier and manner stated within 2 29b. Signature and title of certifier 29c. License number

1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Dav **Physician** 2009 9:02 PM /Medical Leon Fridie July 2, 4c. County of Death Prince George's 8. Date of Birth (Month, Day, Year)
Nov 7, 1950 9. Birthplace (State or Foreign Country) unk South Carolina 10d. Inside City Limits 1 ☐ Yes 2√ No 10g. Citizen of What Country? USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: black. 16b. Kind of Business/Industry Beverage\_ Industry unk 18. Mother's Name (First, Middle, Maiden Surname) Eva Rebecca Neal Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
103 Rubbard Rd Apt 202 Landover Maryland 20785
103 Surratts Road Clinton, 20c. Location - City or Town, State Clinton, MD State Anatomy Board 655 W. Baltimore Street Baltimore, MD - 21201 Stewart FH, Washington DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 1 Yes 2 Wo 1 ☐ Yes 2 ☑ No 26. Place of Death (Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) P0037066 6188 0 ton Hill Rd # 701 0 xon Hill, mp 20745 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) Pais 0 32. Registrar's Signature 31. Date filed (Month, Day, Year)

JUL 13 2009 State Registrar

amend #9,11,12,15,16a&B,17,18,&19a&b Per Ana RD C893 7/14/09 III
State of Maryland / Department of Health and Mental Hygrene

1- State Amend 20b&c, 22 per FH G893 7/29/09 dk
Registrar

Reg. No. 0 0 0

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryla 1 - State Registrar		rtment of H tificate of D			giene Reg. No. 🤈 🎧 🖺 (	00110
			Decedent's Name (First, Middle, Last)			2. Date of De		3. Time of Death	
	Physicia		JAMES W. FOL	K	_			Day Year	
and the same of th	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	07	4c. County of Dea	
-			JOHNS HOPKING BAYNEW MEDICA	L CENTER		BALTI	nont		N/A
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	v. Year)   C	rthplace (State or Foreign country)
	Director		210-24-0023	Yrs.			July 3	1,1931   Ma	ryland
	and w		Usual Residence of Decedent         10a. State         10b. County         10c. C	City, Town or Loc	cation				10d. Inside City Limits
	Maryl f sho	Ď	Maryland Baltimore			D.,,	nda1k		1 □Yes 2X No
	r 28a	Director	10e. Street and Number		10f. Zip Code	Dui	Idalk	10g. Citizen of What C	ountry?
	h with	al D	603 Old North Point Road		2	1224		United Sta	ites
	deat	Funeral	11. Marital Status 12. Was Decedent Ever in U Armed Forces?	J.S. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No	- 14. Race - Am Black, Whi	
98	be filed within 72 hours after death with the Maryland ttal Hygiene.  Ed other than "natural", or Items 23a or 28a-f show event, the Medical Eventinar must be refilled at		1 Never Married 2 Married 1 Yes 2 No		☐Yes 2 <b>/</b> ☐XNo	Specify:	riiodii, oto.)	Specify:	
21215-0036	hours ural"	ed by	3 ☐ Widowed 4 X Divorced Year or Dates:	100 Daniel	In the Manual Comme	Air			White
15	n 72 ""nat	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give I	lent's Usual Occupa kind of work done di OO NOT use retired)	uring most of work	ing	16b. Kind of Business Baltimore	•
712	within jiene. r than "	mo	Elementary/Secondary (0-12) College (1-4or 5+)  12 Years 5 Years		cher			Public Sch	•
D	e filed within al Hygiene. I other than " vent, ine Me	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle,	Maiden Surname)	
Maryland	2 should be and Mental ls marked or raumatic ever	To E	Harry Webster Folk, Sr.			Myra La	avata Wa	11sh	
lar	2 sho and Is ma	·	19a. Informant's Name/Relationship (Type. Print)					er, City or Town, State,	
ر ان	and lealth m 27 her tr		Mr. James W. Folk, Jr. (Son)		Fulbrook				21222
ore	iges 1 If ite or ot				sition (Name of natory or other place		Date	20c. Location - City o	
altimore,	it. Pa Intmer Intant Injury				Service Co			Towson, M	
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic evonce.		21. Signature of Funeral Service Licensee	I Z	ouda-Ruck 1922 Wise	Funeral	Home of	Dundalk,	Inc. 21222
			23a Part 1. Enter the disease or complications that caused the dea shock, or heart failure. List only one cause on each line.						Approximate Interval Between
Lan.	Physician /Medical Examiner				PNEUM				Onset and Death
,			resulting in death)  Due to (or as a conse						
		_	Sequentially list conditions, b. ANOXIC		FIN IN	TURY			
	rted nsit	nine	Sequentially list conditions, if a ny leading to finine date cause. Enter Underlying Cause (Disease or injury						
	execunand and al-tra	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C. CALDIAC ATRES  Due to (or as a consequence of):						
68760,	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edical E	d						
68	tificating phy as the	ledi							
Вох	th cer tendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregr		Ectopic pregnancy			23d. Date of de	
О.	e dea the at ned fo	Physician/M	1 Yes 2 No		Other (specify)			Month	Day Year
<u>q</u> .	that the de ned by the detached	Phy	9 Unknown  Part II. Other significant conditions contributing to death but not re	oulting in the un	derlyine engage eige	n in Dord I	220 Did t	obacco use contribute	to the cause of death?
ds,	signe d be c	i by	Tark ii. Other significant continuous continuum to death but not re-	sulling in the un	derlying cause give	IIII Fait i.			Probably 4 🗆 Unknown
cor	w requir been s should	Completed			_		24a, Was		
Re	he lav e has ige 2	дш					autor	osy prior to death?	autopsy findings available completion of cause of
ta	ysician: The is certificate hidrector, page	e Cc	25. Was case referred to medical			26. Place of Deat	1 Tes	2 <b>≥</b> No   1 □ Ye	s 2 No
>	ystcia s cer direct	m	examiner?	☐ ER/Outpatien	Othe	r· _		dence 6 ☐Other (Sp	acifu)
0	ding Phys th. After this funeral di	L	27. Manner of Death 28a. Date of Injury	28b. Time of Injury	28c. Injury Work			how injury occurred	cony
<u></u>	endir sath. or: Al	atic	2 Accident investigation	,,		es 2□No			
Division of Vital Records,	or Att fter de Sirects in by t	ertification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At I building, etc. (Spec	nome, farm, stre cify)	et, factory, office		28f. Location ( City or To	Street and Number or F vn, State)	Rural Route Number,
	pital	O	29a. Certifier 1 Certifying Physician: To the best of my kn	nowlodge death	occurred at the tim	o data and place	and due to the	aguage(s) and mapper	as stated
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certification ompletely filled in by the funeral director, to	Medical	(Check only one)  2 Medical Examiner: On the basis of examinand manner stated.	nation and/or inv	estigation, in my op	pinion, death occur	red at the time,	date and place, and du	ue to the cause(s)
	To the withing the complete co	ž	29b. Signature and title of certifier		29c. License	number		29d. Date signed (Mor	nth, Day, Year)
			· Mya		25	5 - 000		07-07-	2009
			30. Name and address of person who completed cause of death (Ite Kit Lu 4946				2		
	Sta	0	31. Date filed (Month, Day, Year) 32. Registrar's Sign	nature	2N AVE	no Br	FLY I MOR	E WD 3	11247
	Registra		JUL 13 2009 Lema	B. 190	Los				

DHMH 17 Rev 1/2001

			amend #18 Per	State of M	tin Black arvland / D	Indelible ink. epartment of F	. Ensure Ai lealth and M	l Copies <i>I</i> lental Hva	<b>Are Legible.</b> iene			
		-	For State Registrar	0.0.0 01 1110	Certificate of Death				Reg. No. 2009 22143			
	1. Decedent's Name (First, Middle, Last)			ast)	0.001/			2. Date of Death	3. Time of Death			
	Physicia /Medic		LUCY 1	THE	GR			504	6,200			
	Examin	er	4a. Facility Name (If not institution, give	_	SPICE		r Location of Death	٤	4c. County of Deat			
	Funeral Director		5. Social Security Number 6. 5		e (In yrs. last birth		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) Co	thplace (State or Foreign ountry)		
7	5		Usual Residence of Decedent		10c. City, Town	or Leastion				10d. Inside City Limits		
2	shoy	o	10a. State 10b. County	4		ALTIMO	DPS			1 <b>⊠</b> Yes 2 □ No		
4	r 28a-	Director	MARYLAUD NIP			10f. Zip Code		1	0g. Citizen of What Co	ountry?		
1	23a o	ralD	16 N. PULAS	SKI ST	REET	_ ,	223	(	U.S.A.			
9	items	Funeral	11. Marital Status	12. Was Decedent Armed Forces? 1 ∐Yes 2 🜠		13. Was Decedent of H If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	erican Indian, e, etc.		
036	al", or	þ	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	NO	1 □Yes 2 🗖 No	Specify:		Specify: 12	SLACK		
21215-0036	"natura	Completed	15. Decedent's E (Specify only highest gr	Education rade completed)	16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of work		16b. Kind of Business	/Industry		
212	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland arthem tof Heath and Mental Hygiene. ordant: If tien 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, the Medical Evaminar mast be notified at e.g	dmo	Elementary/Secondary (0-12)	College (1-4or 5	5+)	HOME			OWN H	SME		
		Be C	17. Father's Name (First, Middle, Las					_	Maiden Surname)	Andr a		
yla	snould by and Ment	٩	JOHN HENRY		RAY	SR. Mailing Address (Street	HATTI					
= 0	id 2 sr Ith and 27 Is n traun		19a. Informant's Name/Relationship  MAXINE BROL	(Type, Print)		12 W.PR						
	s 1 and of Health item 27 other t		20a. Method of Disposition		20b. Place of	Disposition (Name of	ce)	Date	20c. Location - City or	Town, State		
<u>m</u>	rages ment of I ant: If ite ury or o		1 🔀 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special		MT. 2	ICN CEMET	ERY 07/11	, I		WE, MARYLAND		
Baltimore,	permit. Pag Departmen Important: any Injury once.		21. Signature of Funeral Service Lice	Mulu		22. Name and Address 505EPH.H. 2140 N.F	ess of Facility	I TO F	TIMERAL I	HOME DDD1217		
			23a. Part 1. Enter the disease, or conshock, or heart failure. List only	nplications that caused y one cause on each li	d the death. Do n	ot enter the mode of dyi	ing, such as cardiac	or respiratory arr	rest,	Approximate Interval Between Onset and Death		
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	Imonas		holisi	m		1 weeks		
	xaminer				reh-	Il ark	-y un	Farci	+	3 weeks		
	p ti	iner	Sequentially list conditions, if any, reading to infinitional cause. Enter Underlying	Due to (or ne	a consequence of		the first			4 . 4		
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Box 6876	earn cernincate be attending physicia for use as the bur	Medi	IF FEMALE:		-							
. Bo	death of	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐No		2 Fetal death	3 ☐ Ectopic pregnan	cv		23d. Date of do Month	,		
P.O.	t the d by the ached		ILLITES ZZINO		at time of death	5 Other (specify)			World	Day Year		
ds,	nar od b leta	Phy	9 Unknown	9 Unknown		5 ☐ Other (specify)		23e. Did to	obacco use contribute			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 0 2 2 1 1 1

		•	For State Registrar	State of Maryland		rtment of H tificate of L			eg. No.	UY	22144
	Physicia	1. Decedent's Name (First, Middle, Last)						2. Date of Dea Month July 8,	th	Year	3. Time of Death 2:30 P M
	/Medic	al	Margaret V. Gunther	4b. City, Town, or Location of Death				nty of Death	2:30 P "		
	Examin	Caroline Nursing Home							Caro		
	Funeral Director			7. Age (In yrs. la 91	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day May 4, 19	18	9. Birthp Coun Mary	lace (State or Foreign viry) Land
	yland	}	Usual Residence of Decedent  10a. State 10b. County	1 ***	Town or Lo					1	0d. Inside City Limits
э Мал	8a-f et	Director	Maryland Caroline		Dento				10g. Citizen o	of What Cour	1 ☐ Yes 2 🖾 No
	be filed within 72 hours after death with the Maryland ald Hyglene. Ide (Hyglene "natural", or items 23a or 28a-f ahow other than "natural", or items 23a or 28a-f ahow avent, the Medical Examitter must be notified at	I Dire	10e. Street and Number 112 Siesta Drive			10f. Zip Code 2162	29		US		
	r death	Funeral	11. Markar States	<ol><li>Was Decedent Ever in U.S Armed Forces?</li></ol>	5. 13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. R	lace - Americ lack, White,	
2-0020	ors afte	þ	1 ☐ Never Married 2 ☐ Married 3 ℃ Widowed 4 ☐ Divorced	1 ☐ Yes 2 K No If Yes, Give Year or Dates:	1	☐ Yes 2☐ No	Specify:		Spe	cify: Whi	te
ה ה	"natur	Completed	15. Decedent's Educ (Specify only highest grade	ation co <i>mpleted)</i>	(Give	lent's Usual Occup kind of work done of OO NOT use retired	during most of work	ing	16b. Kind of	Business/In	dustry
7 7	d withir giene. rr than	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)		acher					ty Schools
מומי	ld be filed ental Hyg ked othe ic avent,	To Be C	17. Father's Name (First, Middle, Last) John Sperlein			1	18. Mother's Nam Gertruc	e (First, Middle, de Gagnan	Maiden Sum	ате)	
Mary	nd 2 shou aith and M 27 Is mar r traumat		19a. Informant's Name/Relationship (Typ Nereus W. Gunther III/S				and Number or Rui Pive Dentor				o Code)
nore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic avent, the Medical Examinar must be notified at ancie.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Re  4 ☐ Donation 5 ☐ Other (Specify)	ce	ace of Dispo metery, cren kwood C	sition (Name of natory or other place enetery	re)	Date /13/09		on-City or To nome Man	
Baitimor	permit. Departm Imports any inju		21. Signature of Funeral Service License	Hellon	5	. Name and Addre eonard J. F 305 Harford	i Road Bai	timore Mar	yland	21214	
3 8	z gz A		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death a cause on each line.	. Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Oue to (or as a opnseque	STIL	kehe	art 1	allo	10	_ !	Mouths
	Examiner		Sequentially list conditions.								
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ence of):							
Ď,	ficate be executed physician and is the burial-transit		that initiated events c. resulting in death) Last	Due to (or as a consequence of):							
08/PN	cate be	edical	d								
O. BOX	The law requires that the death certif te has been signed by the attending tage 2 should be detached for use a:	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Pes 2 De No 9 □ Unknown	ic. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3	Ectopic pregnancy Other (specify)	y			Date of deliv Month	rery Day Year
λ, J	es that gned by se deta	by Ph	Part II. Other significant conditions con	ributing to death but not resu	ilting in the u	nderlying cause giv	ven in Part I.				the cause of death?
ord	w require been si should b	eted	CHOOLC	Jeval J	211	عمو		1 🗆 `			opsy lindings available
Vital Records,		Completed						autor	osy ormed?	prior to co death? 1 \( \text{Yes}	ompletion of cause of
VITA	ician: certific rector,	Be	25. Was case referred to medical examiner?	ospital:	50/0	Ott	26. Place of Dea	th <i>Check on</i> come 5 ☐ Resid		Other (Spec	(6)
Ö	g Phys er this eral di	n; To	27. Mannar of Death	28a. Date of Injury (Month, Day Year)	28b. Time o Injury		1,340,000,000	28d. Describe			''Y)
DIVISION	Attending I death. ctor: After y the funer	catlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1	Yes 2□No	28f Location /	Street and N	umber or Rui	ral Route Number,
<u>&gt;</u>	ator At after of I Direct d in by	Certification;	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	/)	eet, factory, office		City or To	wn, State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical (	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examin	ician: To the best of my knower: On the basis of examination and manner stated.	wledge, deat tion and/or in	h occurred at the ti	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and date and pla	d manner as ce, and due	stated. to the cause(s)
	To th To th	M	29b. Signature and title of certifier	2 Dans	MT	29c. Licens	se number	7/	29d. Date si	gned (Month	Day, Year)
			30. Name and address of person who co	mpleted cause of death (Item	23a) (Type,	Print)	100	4 T	1	24	6290
	<sup>™</sup> St:	ate	31. Date liled (Month, Day, Year)	32. Registrar's Signa	ture /	1 anc	il de		UVC		· ra
	Regist		JUL 1 3 2009	32. Registrar's Signa	par						

	Trease Type of Trine in Black indelible line. Endare An Copies Are Legi
For	State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mary		irtment of F <i>tificate of i</i>			ene . No.	
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Mary  M.	Hoppert		- Edward - Company of the Company of		2. Date of Death Month July 11		3. Time of Death 7:30 a M
	Examin		4a. Facility Name (If not institution, give st. <b>Keswick</b>	reet and number)		Balti			4c. County of Death	
	Funeral Director		221 10 1002		yrs. last birthday) 94 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Pay, Y) Aug 15,	1914 Mary	place (State or Foreign Tand
	//aryland f show ed at	or	Usual Residence of Decedent  10a. State 10b. County  MD n/a	100	c. City, Town or Lo	cation timore				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the Na or 28a-	Direct	10e. Street and Number 2806 Guilford A	venue		10f. Zip Code 2121	.8	10g	. Citizen of What Cou	ntry?
20	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at	by Funeral Director		2. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H f Yes, specify Cuba I □ Yes 2□√No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- po Rican, etc.)	14. Race - Ameri Black, White,	
213-00	thin 72 hour e. an "natural Medical Ex	Completed b	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12)	ation	(Give life. L		pation during most of work d)	king 16	b. Kind of Business/Ir	ndustry
17 DI 16	be filed wintal Hygien of other the event, the	Be	17. Father's Name (First, Middle, Last)  Maurice	4 Hoppe		eacher		ne (First, Middle, Ma SS <b>1</b> E	Educati aiden Surname) Grim	•
Malyi	e e e	Tol	19a. Informant's Name/Relationship (Type Kevin McGarity-nep	e. Print)	19b. Mailin	-	and Number or Ru		City or Town, State, Zi	o Code)
ָרֶ מ	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any Injury or other tra		20a. Method of Disposition  1 Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State	Ob. Place of Dispos cemetery, cren	natory or other plac	ce)		oc. Location - City or T	
Dall	permit. I Departm Importar any Injur		21. Signature of Funeral Service Livensed		. Dau 22	. Name and Addre		ck Towson	Funeral H 21204	
	Physician /Medical Examiner	iner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ations that caused the cause on each line.  Due to (or as a co	nsequence of):		ng, such as cardiac		t,	Approximate Interval Between Onset and Death  Day  Cay
,00,00	ficate be executed physician and s the burial-transit	dical Examiner	that initiated events resulting in death) Last	Due to (or as a co	nsequence of):					74657
O. DOA C	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death.  within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 to No 9 □ Unknown	ic. If yes, outcome pf p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	у		23d. Date of deliv	very Day Year
. L	luires that i	by	Part II. Other significant conditions cont	ributing to death but no	ot resulting in the ur	nderlying cause giv	ren in Part I.	23e. Did toba	cco use contribute to	the cause of death?
	The law req	Completed						24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of 22100
A 110	sician: certific rector,	Be	25. Was case referred to medical examiner?	ospital:		• 3D DOA Oth	or:	th (Check only one)		
5	nding Phy th. :: After this e funeral di	ıtion: To	1  Yes 2  Ario	1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatien  28b. Time of Injury	28c. Injur	4 partituring H	ome 5 ∐ Residend 28d. Describe how	ce 6  ☐Other (Spec rinjury occurred	ify)
	ial or Atter s after dea al Director ed in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - building, etc. (S	At home, farm, stropecify)	eet, factory, office	7.1	28f. Location (Stree City or Town,	et and Number or Rui State)	ral Route Number,
	the Hospl: in 24 hour the Funer: pletely fills	Medical (	(Check only 2 Medical Examination)	iclan: To the best of m er: On the basis of exa and manner stated.	y knowledge, death amination and/or in	vestigation, in my	opinion, death occu	irred at the time, dat	e and place, and due	to the cause(s)
	To To Corr.	×	29b. Signature and title of certifier  Second Second	& ins		29c. Licens	e number		1. Date signed (Month	•
1	2 1		30. Name and address of person who con Jason Black Md	670 ( No	(Item 23a) (Type,	Print) / les St,	Suite		504,MB 2	
1	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's						

Registrar

		For	State of	of Maryla	nd / Dep	partmer	nt of H	lealth	and M	lental Hy	/gier		^	2011
		State Registrar			C	ertificat	e of i	Death			Reg. N	vo. Z U U	9 2	2214
		1. Decedent's Name (First, Midd.	le, Last)							2. Date of D Month		Day Yea		Time of Death
Physici /Medic		Mary Louise	Hi	11						07		200	9   1	1:40 PM
Examir		4a. Facility Name (If not institution	n, give street and nu	ımber)		4b. City,	Town, or	r Location	of Death		4	4c. County of D	eath	
		Casey_House				Rock	vill	_e				Montgom	ery	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs		y) If Unde	r 1 Year	If Under Hours	24 Hrs. Min.	8. Date of B (Month, E	irth	9.1		State or Foreign
Director		579-48-8885	1 □ M 21X F		83 Yrs.	WORTH	Days	Tiouis	IVIII 1.	10/16/				C
nd •		Usual Residence of Decedent		140.0									101 1-	-id- City Limits
aryla shov	<u>_</u>	10a. State 10b. County		100.0	ity, Town or	Location								side City Limits
8a-f	ctc	DC None	<u>:</u>	Was	shingt									Eles Z INO
er 2	Director	10e. Street and Number				10f. Zip	Code				10g. (	Citizen of What	Country?	
23a	ra	4202 13th St.	NW			20	011				U	SA		
r deg	Funeral	11. Marital Status	Armed F	edent Ever in lorces?	J.S. 10	3. Was Dece	dent of H	lispanic Or an, Mexica	rigin? (Spe	ecify Yes or N Rican, etc.)	0-	14. Race - A Black, W		dian,
afte afte		1 ☐ Never Married 2 ☐ Mar	If Yes G	2 <mark>∱</mark> No ive		1 □ Yes		Specify		,		Specify		
S nonus	d by	3 ☑ Widowed 4 ☐ Divorced	Year or I	Dates:								В.	Lack	
nat	lete	15. Deceder (Specify only highe	nt's Education est grade completed)	)	16a. Dei (Gi	cedent's Usu ve kind of wo v. DO NOT u	al Occup ork done d	ation <i>duri</i> ng mos	st of worki	h <i>g</i>	16b.	Kind of Busine	ss/Industry	
A vithin	Completed	Elementary/Secondary (0-12)	College (	1-4or 5+)				d)					- 445	-
c, incl. y far in Z 12 13-0000 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show wher traumatic event, the Modical Exeminar must be rotified at		12th 17. Father's Name (First, Middle,	( a a t )		Hou	sewif	e T	10 Math	ava Nama	(First, Middle			OME	
be f ntal l ed of	Be		Lasi)								e, manu	en Sumame)		
y y y y y y y y y y y y y y y y y y y	မ	Joseph Brown								Brown				
hand range		19a. Informant's Name/Relations	. , .,		1	_						y or Town, Stat	e, Zip Code	9)
and Healt I'm 2		LaVarte Mathis	/son					Washi		n DC 2				
gles :		20a. Method of Disposition 1   Burial 2 □ Cremation	3 ☐ Removal from	State No.	Place of Dis	rematory or c	me or other plac	ce)	L	Date	20c.	Location - City	or rown, S	tate
tmen tant: jury		4 ☐ Donation 5 ☐ Other (5	Specify)	Mer	cemetery, cr tional norial	Park	, it y	i		2009		ndover,		
perfullibility of the Marylan STE 13-10-00 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and be notified at once.		21. Signature of Funeral Service	Licensee	1		22. Name a	nd Addre	ss of Facil	ity Mar	shall'	s F	Uneral	HOme	
1 90 <b>2.29</b>		11/ AND 11/0	MANAU		1	4217 9	th S	St. N	W Was	shingto	n D	C 20011		
		23a. Part . Enter the disease, o shock, or heart failure. List	r complications that t only one cause on	caused the dea	ath. Do not e	enter the mod	de of dyir	ng, such a	s cardiac o	or respiratory	arrest,		Inter	oximate val Between
Physician	11	Immediate Cause (Final disease or condition	. Ac	ute ari	terial	occ1	sior	1					Onse	et and Death
/Medical		resulting in death)	W	(or as a conse										
Examiner		Conventially list conditions	<sub>b</sub> Le	ft foot	tgang	rene								
± d	Examiner	Sequentially list conditions, if any leading to innectal cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conse	quanne offr									
nd rrans	ami	tnat initiated events	V-	rial fi		ation								
e exection and an animal-tr		resulting in death) Last	Due to	(or as a conse	quence of):									
icate be executed physician and strensit in the burial-transit	dical		d. Pu	1monary	у Нуре	rtensi	.on							
ertificating plans to as t		IF FEMALE:												
leath certifi attending for use as	an/I	23b. Was decedent pregnant		itcome of pregr birth 2  Fet		B 🗆 Ectopic p	oregnanc	V				23d. Date of		
ed fo	sici	in the past 12 months? 1 ☐ Yes 2 ☒ No		gnant at time of		5 ☐ Other (s						Month	Day	Year
The law requires that the death certified has been signed by the attending bage 2 should be detached for use as	Physician/M	9 ☐ Unknown												
res tha signed be det	by	Part II. Other significant conditi	ons contributing to c	leath but not re	sulting in the	underlying o	ause giv	en in Part	1.	23e. Did	tobacc	o use contribut	e to the cau	use of death?
w requires been si should b		Hypertension								1 🗆	] Yes	2 □ No 3 □	Probably	4 <u>₩</u> Unknown
law re as be 2 sho	Completed	Metastatic me	lanoma							24a. Wa		24b. Were	autopsy fi	ndings available
The cate has	E									per	opsy formed?	? death	1?	on of cause of
sician: The certificate rector, pag	ø	25. Was case referred to medica	d []					26. Plac	e of Death	1 □Yes (Check only		INU   I LL I	′es 2⊠l	NO
ysici is cer direct	0.0	examiner? 1 ∐ Yes 2 🔯 No	Hospital:	Inpatient 2	TER/Outpat	ient 3∏ Do	Oth	or:				6 <b>⊠</b> Other (5	Specify) L	Osnice
g Phy er thi		27. Manner of Death	28a. Date	of Injury	28b. Time		28c. Injur Work	7 🗆 🗅				jury occurred	, roony) I.	SPATCE
Attending Physician: rdeath. sctor: After this certification of the funeral director, processed in the force of the funeral director, processed in the funeral director, processed in the funeral director, processed in the funeral director, processed in the funeral director, processed in the funeral director, processed in the funeral director, processed in the funeral director, processed in the funeral director, processed in the funeral director, processed in the funeral director, processed in the funeral director, processed in the funeral director, processed in the funeral director, processed in the funeral director, processed in the funeral director director directors.	fication	1 ☑ Natural 5 ☐ Pendir 2 ☐ Accident Investi	ng ( <i>Moi</i> igation	nth, Day, Year)	Injury	′ м		k? Yes 2□	]No					
des des	fica	3 ☐ Suicide 6 ☐ Could	not be 28e. Place	e of Injury - At I	nome, farm,	street, factor			-	28f. Location	(Street	and Number or	Rural Rou	te Number.

To the Hospital or A within 24 hours after or To the Funeral Direct completely filled in by City or Town, State) Medical Certi 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 63 748 07/2/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Jocelyne Kouatchou, MD

201 East University Pkwy, Baltimore, MD 21218
32. Registrar's Signature

State Registrar

			1 - State of Maryland / De State of Maryland / De	epartment of F Certificate of L			giene Reg. No. 20	09	22147
	Physicia	an	1. Decedent's Name (First, Middle, Last)			2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic		Martina Mary Haffner			July 6	5, 2009		3:10 A M
	Examin	er	4a. Facility Name (If not institution, give street and number)	_ "	Location of Death		4c. County		
-			18125 Coachmans Road  5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	Germant	OWN If Under 24 Hrs.	8. Date of Bir	th	gomer 9 Birthol	y lace (State or Foreign
	Funeral Director		0.45-50-7971 1□ M 2 🖾 F 56 Yrs	Months Days	Hours Min.	June 30,	1953	Illir	trv)
	_		Usual Residence of Decedent						
rylan	show Lat	_	10a. State 10b. County 10c. City, Town or	Location				10	Od. Inside City Limits
е Ма	8a-f s	Director	Maryland Montgomery Germanto				45 600		1 □ Yes 2 No
vith th	a or 2	ä	10e. Street and Number	10f. Zip Code			10g. Citizen of V		
eath v	s 238	eral	18125 Coachmans Road  11 Marital Status 12. Was Decedent Ever in U.S.	20874	ienanic Origin? (Sn	ecify Ves or N	United	Stat e - America	
ter de	item	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 ☑ Married  1 □ Yes 2 ☑ No	<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>	an, Mexican, Puerto	Rican, etc.)	Blac	k, White, e	
OUSO nours aft	al", or	þ	If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 🔀 No	Specify:		Specify	. Wh	ite
2-0 72 ho	natur	Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	ecedent's Usual Occup	ation during most of work	ina	16b. Kind of Bu	usiness/Ind	lustry
ithin A	Je.	ηdμ	Elementary/Secondary (0-12) College (1-4or 5+)	fe. DO NOT use retired	1) -	-	01	. •	
led wij	fygier her tf nt, th			tive Assistan	18. Mother's Name		Consul		
d be file	ntal F ed ot ever	Be	17. Father's Name (First, Middle, Last)					16)	
hould	nd Me mark matic	ဍ	Paul Kleist Cuneo  19a. Informant's Name/Relationship (Type. Print)  19b. M	failing Address (Street	Mary Lou			State Zin	Code)
Ma d 2 s	Ith ar 27 is 1 trau	- 3		25 Coachmar					
a 1 ar	f Hea item			isposition (Name of crematory or other place	10) T1	Date	20c. Location -		
Page:	nt: If		1 🗆 Burial 2 🖾 Cremation 3 🗀 Removal from State	ry Crematorium	0.04	9,	Bethes	da. N	Maryland
Dallillor permit. Pages	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expression rust be neithed at once.		21. Signature of Funeral Service Licensee	22. Name and Addre Robert A. Pum	ss of Facility p <b>hrev Funer</b> a	al Home/E	Rockville,	Inc.	
			23a. Part 1. Enter the disease, of complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	300 West Montg				Tand 2	Approximate
Dh	ysician		Immediate Cours (Final						Interval Between Onset and Death
	ysician Medical		disease or condition resulting in death)  Respiratory Fail  Due to (or as a consequence of):					-	
Ex	aminer		Metastatic Saliv	ary Gland	Cancer				
Q	#	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Dust (of as a consequence of):	- 23					
ecute	and -trans	Examiner	Taily, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last C.  Due to (or as a consequence of):						
oo / oo, ficate be executed	attending physician and for use as the burial-transit	al E	Due to (of as a consequence of).						
DO /	phys s the	edical	d						
OI VITAL RECOIDS, F.O. DOX of Physician: The law requires that the death certif	nding Ise a	J/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy				23d. Da	te of delive	ery
death	e atte d for i	Physician/M	in the past 12 months?  1	3 ☐ Ectopic pregnance 5 ☐ Other (specify)	y 		Mo	onth	Day Year
t the	by th tache	hys	9 Unknown						
o, –	igned be de	by F	Part II. Other significant conditions contributing to death but not resulting in the	ie underlying cause giv	en in Part I.				ne cause of death?
<b>COLUS,</b> w requires t	een s					1 🗆	Yes 21x No	3∐ Prob	pably 4 Unknown
a C	hasb e2sh	Completed				24a. Was	psy	prior to cor	psy findings available mpletion of cause of
# # #	cate; pag	ပ်				1 ☐ Yes		death? 1 □ Yes	2 🗆 No
VILCUI sician;	certif	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	otiont 3 DOA Oth	26. Place of Deat			-	
2 E	r this ral dii	1.To	1 ☐ Yes 2 ☑ No	atient 3 1 DOA	4 LI Nursing Ho		idence 6 Oth how injury occur		y)
SIOII	th. : Afte : fune	ţ	1 X Natural 5 ☐ Pending (Month, Ďay, Year) Inju 2 ☐ Accident investigation		ḱ? Yes 2 □ No		,,		
Affer	r dea e <b>ctor</b> by the	ertification:	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm	, street, factory, office			(Street and Numb	per or Rura	al Route Number,
5 8	s afte	Cert	4 Homicide determined building, etc. (Specify)			City of To	iwn, State)		
Hospit	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Medical (	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, of the basis of examination and/one and manner stated.						
To the	within To the compl	Me	29b. Signature and the of certifier	29c. Licens	e number		29d. Date signe	ed (Month,	Day, Year)
			John Jeeken	MD03	6169		July 8	, 200	19
			30. Name and actiress of person who completed cause of death (Item 23a) (Ty						
	-01-		John Deeken, M.D. 3800 Reservoir  31. Date filed (Month, Day, Year) 32. Registrar's Signature	Koad, N.W.	, Washing	ton, Do	20007		
	Sta Registr		111 1 3 2000	a Kel					

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 **Physician**  $P^{M}$ July 5:10 Paul Norman Jenner /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rockville Montgomery Shady Grove Adventist Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, July 19, Age (In yrs. last birthday, If Under **Funeral** Days Hours 1 X M 2 □ F 562-40-3311 74 1934 Colorado Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County r than "natural", or items 23a or 28a-f show 1 ☐ Yes 2X No Director Maryland | Montgomery Rockville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4 Eaglebrook Court 20854 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after 1 ∑Yes 2 □ No If Yes, Give Year or Dates: 1953–1974 1 Never Married 2 Married Maryland 21215-0036 1∐Yes 2XXNo Specify Specify: White ð 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the IN. Elementary/Secondary (0-12) College (1-4or 5+) U.S. Army/Military Enlisted Master Sergeant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wilma Fern Lackey Delbert Oren Jenner ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Eaglebrook Court, Rockville, Maryland 20854 Fatma Uner Jenner / Wife Baltimore, 20b. Place of Disposition (Name of Commetery, crematory or other place Arlington National Cemetery 20c. Location - City or Town, State 20a. Method of Disposition August 4, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2009 Arlington, Virginia 21. Signature of Funeral Service Licensee Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. that the -M01360 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Days **Physician** Sepsis /Medical Due to (or as a consequence of): Examiner Days Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 0 Day 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No o. the 9 Unknown detached 9 Unknown signed by the 9. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed certificate 1 ☐ Yes 2X No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician; director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔯 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certif D0064413 July 8, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, Maryland 20850 Juanita L. Smith, M.D. 31. Date filed (Month, Day, Year) 32. Reistrar's Signature

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ZZPM Month Day Year Physician 07 2009 /Medical 4c. County of Death acility Name (If not institution, give street and number) City, Town, or Location of Death Examiner ff Unde Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, In yrs. last birthday) **Funeral** 1 M 2 □ F Months Days Hours 218-44-206 Yrs August 67. Director Usual Residence of Decedent 1.2 should be filed within 72 hours after death with the Maryland h and Mental Hyglene. 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State ral", or items 23a or 28a-f shov 1 Yes 2 No Funeral Director MARYland 10g, Citizen of What Country? 10e. Street end Number 10f. Zip Code E, USA Lake 21212 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specity: AMERICAN Specify à 3 Widowed 4 Divorced Completed permit. Pages 1 and 2 should be filed within 72 hr. Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation 16b. K d of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be KIRKIAN Geneur ONE! ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21212 brother WHIMCRE. MARYAND 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 Removal from State 14/13,2009 4 Donation 5 DOther (Specify) 22. Name and Address of Facility Nancy 21. Signature of Funeral Service Licensee M. WAILACE FUNERAL SPRINGE 3405 Stract. W. BAHIMOVE Approximate Interval Between Onset and Death 23a. Part 1. Enter the dis-shock, or heart fail r e, or comilications that caused the de th. List only one clust on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or n a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to (phas a consequence of): or Attending Physician: The law requires that the death certificate be executed for use as the burial-trans ue to (or as a consequence of P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached to 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. 1 ☐ Yes 2 ☐ → 6 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform this certificate 2 🔼 1 ☐ Yes 2 12 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 Yes 1 hpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of reath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 10 Jural 5 Pending investigation ours after death.

neral Director: A
filled in by the fu death. 1 ☐ Yes 2 🗆 No Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. 29b. Signature and title of certifie

State Registrar 30. Name and address of person who completed cause of deat

3 2009

31. Date filed (Month, Day,

23a) (Type, Print

(Item

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death /onth Day Year **Physician** 1a 00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore City Johns Hopkins Bayview Medical Ctr. If Under 24 Hrs. Hours Min. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days MCM 2□ F 87 166-14-3642 Oct. 13,1921 Shamokin, PA Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~~ "any injury or other traumatic even." 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 □Yes 2 No Baltimore Co. Director Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 433 Pembrooke Blvd. United States 21224 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1027es 2 ☐ No 14. Race - American Indian 11. Marital Status Black, White, etc. TYPES, Give Year or Dates: 1 Never Married Married 1 ☐ Yes 2√√No Specify þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Western Electric Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Years Corp 12 Years 18. Mother's Name (First, Middle, Maiden Surname) unknown 17. Father's Name (First, Middle, Last) Be ဂ Stanley Kohoskie Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Churchville, MD Bowman Road Mary Whitaker (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gdns. 7/10/2009 Middle River, MD 4□Donation 5(NOther (Specify) Entombment 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 21. Signature of Funeral Service Licensee Toslas 21222 7922 Wise Ave. Dundalk, Maryland 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 4091 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte Year in the past 12 months? Month Day Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? \$ cate has been signated by page 2 should b 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No certificate 1 Yes Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yes 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Blvd. 21224 Baltimore , Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July <sup>Day</sup> 2009 Year **Physician** 5:00A June Gertrude Luques /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Westminster Carroll Lutheran Village Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 158-16-2746 1 □ M 2√□ F 84 Director 11-13-1924 New Jersey Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State r than "natural", or items 23a or 28a-f show 1 ☐ Yes 2√2 No Director MD Carroll Westminster 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21157 USA 201 St. Mark Way Funeral Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 2 3X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Potter Gardening 7 Is marked other traumatic event, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Health and Mental John Smitansky Gertrude Behrens 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau Leslie I. Durrant-daughter 4698 Egg Hill Dr. Manchester, MD 21102 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐ Removal from State South Carroll Crem. 7-10-09 Winfield, MD 22. Name and Address of Facility Fletcher Funeral Home, P.A. 21. Signature of Funeral Service Licensee Thomas Main St. Westminster, MD 21157 254 E. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyin, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on a ch line. Immediate Cause (Final **Physician** roughl disease or condition resulting in death) /Medical Due to (or as onsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Box 68760 physician Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a 9 Unknown 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has perform certificate 1 ☐ Yes Division of Vital Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Yes 25 No 27. Manner of leath Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 124 hours after death.

le Funeral Director: βoletely filled in by the fu 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. the the within 7 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

		-	For State Registrar	State o	f Maryland		artment o <i>rtificate c</i>	f Health and I If Death		giene Reg. No. 🤈 [	100	22152
			1. Decedent's Name (First, Middle	, Last)					2. Date of Dea	ath Day	Year	3. Time of Death
	Physicia /Medic	_	Teresa Sheng	-Ping Lou					July		2009	2:48 P M
4.	Examin		4a. Facility Name (If not institution				4b. City, Town	, or Location of Death		4c. Coun	ty of Death	1
			Montgomery Ho				Rockv		T = 0 + 1 + 1 = 1		gomer	y pplace (State or Foreign
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs. la	a <i>st birthd</i> ay) Yrs.	If Under 1 Ye Months Da		8. Date of Bird (Month, Da	y, Year)	Cou	intry)
	Director		492-62-6628 Usual Residence of Decedent		63				July 10	, 1945	Chi	na
	land ow		10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	Many a-f sh	ż	Maryland   Montg	omery	Ве	thesd	а					1 □Yes 2X No
	or 28.	Director	10e. Street and Number				10f. Zip Cod	le		10g. Citizen o	f What Cou	untry?
	23a		10107 Baldwin	Court				20817		United		
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the "Molral Examinar must be notified at ance.	Funeral	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Marr</li></ul>	Armed Fe	2 <b>X</b> No		Was Decedent If Yes, specify ( 1 □Yes 2 🛣	of Hispanic Origin? (S Cuban, Mexican, Puert No <i>Specify:</i>	pecify Yes or No o Rican, etc.)	- 14. R B	lack, White,	rican Indian, , etc. .sian
Maryland 21215-0036	ural",	d by	3 ☐ Widowed 4 💆 Divorced	If Yes, G Year or D	Dates:					16b. Kind of		
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12	within iene. <b>than</b>	omp	Elementary/Secondary (0-12)	College (		Consu		,			relopm	oftware ment
p	i Hyg other ent,	Be C	17. Father's Name (First, Middle,	Last)				18. Mother's Nar		, Maiden Sum		
/lar	uld be Menta Irked Itic ev	To E	Ching-Yun Lo	u					hung Ti			
lar)	2 sho and is ma	'n	19a. Informant's Name/Relations			1		reet and Number or Ru				
≥,	and lealth m 27 her tr		Anne Wang /Dau	ghter	look B			in Court,	Bethesd	a, Mary		
Baltimore,	ges 1 nt of H If ite or ot		20a. Method of Disposition 1 ☐ Burial 2 🎖 Cremation		State Mon	emetery, crei	osition (Name of matory or other LV	July	11.		•	
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Ba	perm Depa Impo any i		21. Signature of Funeral Service	ensee	MO1:	1Ř 360 ∣ 7	obert A. 557 Wisc	Pumphrey Fun onsin Avenue	eral Home/ . Bethesda	Bethesda Marvla	a-Chevy and 208	7 Chase, Inc. 314-3501
			23a. Part 1. Enter the disease, or	complications that	caused the death						ANG ZOO	Approximate Interval Between
	Physician	k S	shock, or heart failure. List Immediate Cause (Final disease or condition		each line. [etastat:	ic Col	on Cano	or				Onset and Death
	/Medical		resulting in death)	a.	(or as a consequ		on cane					
	Examiner		Sequentially list conditions	b								
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to	(or as a consequ	uence of):						
_	xecut and Il-tran	хап	that initiated events resulting in death) Last	c	o (or as a consequ	uence of):						
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687	tificate g phy as the	edic		u.								
Вох	leath certific attending p I for use as	M/m	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, or	utcome of pregna	incy	☐ Ectopic preg	nancy		I .	Date of del	
-	ed for	sicia	in the past 12 months? 1 ☐ Yes 2 🛣No		gnant at time of c		Other (special				Month	Day Year
P.0.	at the	Physician/Me	9 Unknown			ultima in the s	Inderlying cour	a given in Part I	23e Did	tohacco use c	ontribute to	the cause of death?
	w requires that the death certificate be executed to been signed by the attending physician and should be detached for use as the buriat-transit	þ	Part II. Other significant conditi	ons contributing to	geath but not resi	uning in the t	indenying caus	s given in raiti.		Yes 2 □ No		
Ö	requ been should	Completed							24a. Was	an 24	1h Were au	utopsy findings available
Rec	e la has Je 2	du							auto	opsy ormed?	prior to death?	completion of cause of
[a]	i <b>cian:</b> Th certificate ector, pag		25. Was case referred to medica					26 Place of De	1 □Yes ath (Check only		1 L Yes	s 2□No
>	Physician: r this certific ral director,	o Be	examiner? 1 ☐ Yes 2 🎇 No	Hospital:	Inpatient 2	ER/Outpatie	ent 3 🗆 DOA				Other (Spe	ecify) Hospice
0	ig Phys ter this neral dir	n: To	27. Manner of Death	/8.4 a	e of Injury onth, Day, Year)	28b. Time o	of 28c.	Injury at Work?	28d. Describe			
sior	Attending r death. ector: After by the funer	atic	1 X Natural 5 ☐ Pendir 2 ☐ Accident investi	gation			М	1 ☐ Yes 2 ☐ No	-			
Division of Vital Records,	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be nined 28e. Plac buil	ce of Injury - At he ding, etc. (Specii	ome, farm, st fy)	reet, factory, of	fice	28f. Location City or To	(Street and Ni wn, State)	ımber or Ru	ural Route Number,
	pital ours a leral C	ခို	29a. Certifier 11 Certifyi	na Physician: To ti	ne best of mv kno	wledge, dea	th occurred at	he time, date and place	e, and due to th	e cause(s) and	d manner a	s stated.
	To the Hospital within 24 hours a To the Funeral I completely filled	ledical	(Check only 2 Medical one)	Examiner: On the	basis of examina inner stated.	ation and/or i	nvestigation, in	my opinion, death occ	urred at the time	e, date and pla	ce, and due	e to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certific	r O				cense number		29d. Date si	gned (Mont	th, Day, Year)
			J. Kouert	cheu,	MI		10	53748		July	10, 2	2009
			30. Name and address of person					20144	n .		6 - 1	1 20055
			Jocelyne T. K 31. Date filed (Month, Day, Year,		-			r Mill Rd.	, Kockv	ılle, M	aryla	and 20033
	Sta Registi			3 2009	Registrar's Signa	1. 4	barker					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #17 Per FH 6893 7/20/09 III. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day Month Year **Physician** 09 2:45 Carl W. Miles Julv 0 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** NA Baltimore Bluepoint Nursing Home 9. Birthplace (State or Foreign Country)
GA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) -6-21-31 **Funeral** Days Min. Hours 217-24-8593 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits show 10a. State 10b. County ed other than "natural", or Items 23a or 28a-f show event, the involcal Evaluation results the notified at XXYes 2 □ No MD NA Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with Miles 325 Radnor <u>Avenue</u> Funeral 21212 USA filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married X Married 2 No African Baltimore, Maryland 21215-0036 Specify: American 1 ☐ Yes 2 No Specify. ۵ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore City permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "any injury or other traumatic event, I'm Magonee. Elementary/Secondary (0-12) College (1-4or 5+) Fire Department th Grade <u>Fire Fighter</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ernes t Miles, Sr. Catherine Phelps ၉ Ernest 19a. Informant's Name/Relationship (Type. Print Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Antoinette Miles-Booker 325 Radno<u>r Road Baltimore, MD 21212</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest VA 07-20-09 Owings Mills, MD 22. Name and Address of Facility Wylie Funeral Home P.A. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fund Service in see 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, o shock, or heart failure. Light Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line Immediate Cause (Final disease or condition resulting in death) MELLIT **Physician** IMBETES /Medical Due to (or as a consequence of): **Examiner** CHEXIF Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit The law requires that the death certificate be executed クでそんでと ALZHEIMER Due to (or as a consequence of): P.O. Box 68760, been signed by the attending physician should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1415017 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy this certificate 2 🔀 1 ☐ Yes 1 ☐ Yes Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ZINO 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 2 🗆 No 1 Yes 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 se of death (Item 23a) (Tyo, Print)

DHMH 17 Rev 1/2001

State Registr<u>ar</u> 31. Date filed (Moi

09-05376 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Maurice McFadden State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical Examiner July 8, 2009 Maurice McFadden 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore University Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours Months Days Director 215-33-1171 1X M 18 07 - 02 - 91Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 28a-f show NA Baltimore items 23a or 28a-f shoust be notified at once. within 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2139 Cambridge Street 21231 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 XNever Married Married 2 X No Yes 5 If Yes, Give Year Yes 2 X No specify: Widowed Divorced ğ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical marked other than MD 21215-0036 9th Grade NA Clerk Total Pages I and 2 should be filed wiment of Health and Mental Hygie tant: If item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) or other traumatic event, McFadden, Be Maurice Dawn D. 19a. Informant's Name/Relationship (Type, Print) 2139 Cambridge Street Dawn D. Howell-Mother 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Krial 2 Cremation 3 Removal from State permit. Pages
Department of
Important: I 07-15-09 Arbutus Mem. Pk. Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Street Gilmor **Physician** failure. List only one cause on each line. /Medical a, Gunshot Wounds (2) to Chest Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical UNPENDED **AMENDED** attending physician for use as the burial -Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death Other (Specify, signed by the atte 1 Yes 2 No 9 Unknown q Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Completed ficate has been si 24a, Was an autopsy After this certificate ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Other4 Nursing Home 5 Inpatient 2 V ER/Outpatient 3 1 Yes 28a. Date of Injury Jul 8, 2009 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Subject shot Natural Yes 2 V No Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide determined (Specify) Local Street

Howell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD Baltimore. Arbutus, MD Wylie Funeral Home P.A. Baltimore 23a Fart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interva Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? Yes 2 ✔ No 3 Probably 4 \_\_ Unknown 24b. Were autopsy findings available prior to completion of cause of performed? death? 1 🗸 Yes To the Hospital or Attending Physician: Residence 6 28d. Describe how injury occurred Certification filled in by the f within 24 hours after death, 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1700 Division Street, Baltimore, Md. To the Funeral 29a. Certifier 1 Certifying Physician to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and marther stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie O.C.M.E July 9, 2009 30. Name and address of erson who completed cause of death (Item 23a) OCME 111 Penn Street, Baltimore, MD 21201 Mary G. Ripple MD. Deputy Chief Medical Examiner 31. Date filed (Month, Day, Year) State ORIGINAL Registrar DHMH 17 Rev 1/2001

2335 hrs

10d. Inside City Limits

No

X Yes 2

Health Care

NA

USA

14. Race - American Indian, Black,

Specify: American

White, etc. African

Foreign CountryMD

State of Maryland / Department of Health and Mental Hygiene

Decoder's Name (Piet, Middle, Lea)   Decoder's			-	1- State of Maryland / Department of Health and Mental 1  Certificate of Death		. No. 🥎 🎧	100	20155
Try program of the property of		Disconist		1. Decedent's Name (First, Middle, Last)  2. Date of Month				3Time-of Death
The special power of the control of	12 A80			Pohert Negars	27 (			2 2 2 2 b w
Store   Property   Company   Compa				4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	,	4c. Coun	ty of Death	
Physician   Court	E ST				f Birth		9. Birthr	lace (State or Foreign
The Sale   10c. Coarry   10c. Sale   10c. Coarry   10c. Sale   10c. Coarry   10c. Sale   10c. Coarry   10c. Sale	2				1, Day, Y 25-1	941		
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The property of the property o		h with	al D	3135 Freestone Court 21009		USA	_	
The property of the property o	36	s after deat , or items 2 aminer mu			or No-	BI	ack, White,	etc.
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The second of paperson of the	121	within ane. than '	ם	Elementary/Secondary (0-12) College (1-4or 5+)  Tron Worker	I	ocal	#16	KELD
The second of paperson of the	75	Hygie Hygie ther i			iddle, Ma	aiden Surn	ame)	
The second of paperson of the	an	d be ental ked o c eve	o Be	Louis Meyers Marie Kee	gan			
The second of paperson of the	Z.	shoul nd M marl	F	19a. Informant's Name/Relationship (Type. Print) wife	lumber, (	City or Tow	n, State, Zi	o Code)
20. Welfard of Deposition   Deposition   Part of Disposition   Deposition   Deposit		nd 2 aith a 27 Is r trau		Rose F. Meyers 3135 Freestone Ct., Ab:	ingc	don, N	ID 21	009
Physician Modical Examinor  Physician Physician	more,	0 0		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  Dulaney Valley  7/14/200	9 T	imon	ium,N	Maryland
Physician Medical Examiner    Part   Description   Physician   Phy	Balti	permit. Departri Importa any Inju		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Joseph  26.3 S. Conkling St.J.	N. Balt	Zanr	nino ce.MD	Jr. FH 21224
Due to (or as a consequence of):    Due to (or as a consequence of):   Due to (or as a consequence of consequen		/Medical		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions.  b.				Approximate Interval Between Onset and Death
FFEMALE:   1   1   1   1   1   1   1   1   1	8760,	ate be executed hysician and the burial-transit	lical Examine	resulting in death) Last Due to (or as a consequence of):	ni.	n		
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death  1	Box.					1		
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death  1		luires that signed by	by	Age in other significant conditions continuous to treatment not recently in the disastying access great at the				
1	Reco	The law rec ate has beel bage 2 shou	omplete	24a	autopsy perform	ned?	prior to c death?	ompletion of cause of
1	ita	lan: ertifica ctor, p		25. Was case referred to medical 26. Place of Death (Check	only one	)		
1	۲ \	hysic his ce Il dire	2	1 Yes 2 10 10 10 10 10 10 10 10 10 10 10 10 10				eify)
State  28f. Location (Street and Number or Rural Route Number, building, etc. (Specify)  28e. Place of injury - At home, farm, street, factory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28g. Place of injury - At home, farm, street, factory, office  28g. Place of injury - At home, farm, street, factory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)  29a. Certifier  (Check only one)  29a. Certifier  29a. Certifier  (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Company of the policy of th		ing P			cribe no	w injury oc	currea	
29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Company of the cause (s) and manner as stated.  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Company of the cause (s) and manner as stated.  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Company of the cause (s) and manner as stated.  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Company of the cause (s) and manner as stated.  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Company of the cause (s) and manner as stated.  29d. Date signed (Month, Day, Year)  31. Date filed (Month, Day, Year)  32. Registrar's Signature	ivisio	ten tor the	rtificati	2 Accident 3 Suicide 4 Homicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			ımber or Ru	ral Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Lei Jia Chen 22 South Greene Street, Batainore, Maryland, 2(2)  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature		Hospital of the hours at Euneral E			to the ca	ause(s) and ate and pla	I manner as ce, and due	stated. to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Lei Jia Chen 22 South Greene Street, Batainore, Maryland, 2(2)  State 31. Date filed (Month, Day, Year)  32. Registrar's Signature	+1	thin 2 the mplei	Med	29b. Signature and title of certifier 29c. License number				
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		FSFS		A MD MPI 114442204	9	Jul	410	,2009
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature				30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  (2 Till Chan Base South Greene Street Bate	in	ore	Many	land, 2(20)
	60			te 31. Date filed (Month, Day, Year) 32. Registrar's Signature				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** are Markuson July /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Bathmore Glunst HOSPICE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday **Funeral** Months Days 1 □ M 2 🔽 F 79 **Director** <u>213–24–0125</u> September Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director Maryland Baltimore Timonium 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21093 U.S.A. 400 Plumridge Court, #103 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No þ Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Music Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walden Richards Marie Fooks ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health 400 Plumridge Court, #103, Timonium, Maryland 21093 Roy H. Markuson / Husband item 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Mansoleum 20a. Method of Disposition Date permit. Pages Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 07-16-2009 4 Donation 5 XOther (Specify) Fintament 21. Signature of Ineral Service Licenses 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Skun **Physician** Cell Cancer, /Medical resulting in death) Due to (or as a consequence of) Examiner DI scase to Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the certificate has been signed by the attending rector, page 2 should be detached for use as . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by failure 24a Was an Division of Vital To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only on Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number D0068286 W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

West

31. Date filed (Month, Day, Year)

MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

20c. Location - City or Town, State Timonium, Maryland Ruck Towson Funeral 1050 York Road, Towson, Maryland Approximate Interval Between Onset and Death ear Rar 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) Towsontom Blvd, Battimore, MD 21204 555 West 32. Registrar's Signature **ORIGINAL** 

3. Time of Death

5:35 PM

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 21 No

Maryland

Baltimore

14. Bace - American Indian. Black, White, etc

Specify: White

State Registrar

To the Hospital or Attending Physician: The law requires that the death certificate be executed physician a s the burial-1 Box 68760 Ö σ. Division of Vital Records, Il Director: A within 24 hours a

1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last, Year Month **Physician** gth 4:20 PM JULY 2007 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Union Memorial BaltiMore Security Number Date of Birth (Month, Day, 03 - 12 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Year) Months Hours **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 28a-f show 1 Yes 2 □ No Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 6 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No Iffes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No "natural", or Specify: 3 ₩Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Magny injury or other traumatic event, the Magny injury or other traumatic event, the Magny injury or other traumatic event, the Magnotice. Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last ဥ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 2 DAYS Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** SEVERE /Medical Due to (or as a consequence of): Examiner 2 SAYS BOWEL 1JCHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner UNKNOWN ADV ANCED DEMENTA Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ THRIVE FAILURE 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD AT 2438946-H8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD 21218 ANDREEA OLARU I UNION MEMORIAL HOSPITAL, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

-05359 adys A. Mendoz	za	Please Type or Print in Black Indelible Ink. Ensure A State of Maryland / Department of Health and N	Mental Hygiene	JU
Physician	1- Re	For State  State  Certificate of Death  Continue (First, Middle, Last)  Gradys Adelson Mendoza	Reg. No.  2. Date of Death  Month Day Year 0018 hre	7
/ Examin	er	a. Facility Name (If not institution, give street and number)  Suburban Hospital  4b. City, Town, or Loc Bethesda	Montgomery	
Funeral Director	5		Hours Min. 8. Date of Birth (MM/DD/YYYYY) 9. Birthplace (State or Foreign Country) Honduras	gn
21215-0036 uld be filed within 72 hours after death with 1 Mental Hygiene. marked other than "natural", or items 23; c event, the Medical Examiner must be not	3e Completed by Funeral Director	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced or Dates: 15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Usual Occupation during most of working life. Decedent's Name (First, Middle, Last)  Ruben Mendoza Flores  12. Was Decedent Ever in U.S.  Armed Forces?  1 Yes, Sive Year  1 Yes, Give Year  1 Decedent's Usual Occupation during most of working life. Decedent's Usual Occupation during most of working life. Decedent's Usual Occupation during most of working life. Decedent's Usual Occupation during most of working life. Decedent's Name (First, Middle, Last)  Ruben Mendoza Flores  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispating Address (Street In Yes, specify Cuban, Mariting Addr	n (Give kind of work done 16b. Kind of Business/Industry NOT use retired)	L
Baltimore, N permit. Pages I and Department of Healt Important: If item injury or other tran		20a. Method of Disposition .  1	cery 07/20/2009 Alianzavalle, Hondu	rval
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	Physician/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  AHEAD And Chest Injuries  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  AMENDED  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Pregnant at time of death 5 Other (Specify)  9 Unknown	Ectopic pregnancy 23d. Date of delivery Month Day Year	2
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici rompletely filled in by the funeral director, page 2 should be detached for use as the buri	Certification: To Be Completed by	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1  Natural 5  Pending Investigation 3  Suicide 6  Could not be determined	1 Yes 2 ✓ No 3 Probably 4 Unkno  24a. Was an autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes 2 No  a of Death (Check only one)  Other  Nursing Home 5 Residence 6 Other:  28d. Describe how injury occurred Driver auto auto Collision  28f. Location (Street and Number or Rural Route Number, or Town, State) 1 495 @ Cabin John Parkway, Potomac , MD	ilable e of
	State	31. Date filed (Month, Day, Year) 32. Kegistrar's Signature		

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Gallo State of Maryland / Department of Health and Mental Hygiene

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2	U	U	3	221	0	-

R	For State Certificate o		Reg. No.	3. Time of Death
Physician/ Examiner	Decedent's Name (First, Middle,Last) Franklin Geovany Ma Franklin Gallo Manz	nzanares Gallo anares	Month Day Year July 7, 2009	
	a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of De.	ath 4c. County of Montgom	
	Outer Loop of I-495 at Cabin John Parkway  Social Security Number 6, Sex 7, Age (In yrs. last birthday)	Potomac  If Under 1 Year   If Under 24		9. Birthplace (State or Foreig
Director	none 1 X M 2 F 37 Y	Months Days Hours	03/23/1972	Honduras
	Jsual Residence of Decedent			10d. Inside City Limits
<b>*</b> .	VA Fairfax County Spr	ingfield		1 Yes 2 X N
the Maryland or 28a-f sh	10e. Street and Number	10f. Zip Code	10g. Citizen of Wh	
h the N 23a or notifies	6103 Amherst Ave.	22150 Vas Decedent of Hispanic Origin?		- American Indian, Black,
er death with the Maryland or items 23a or 28a-f show r must be notified at once. Funeral Director	1 Never Married 2 X Married Armed Forces?	Yes, specify Cuban, Mexican, Pu	erto Rican, etc.)	
firer de	3 Widowed 4 Divorced If Yes, Give Year 1	X Yes 2 No specify:HO		white
hours aft natural" Sxamine ed by	during	ent's Usual Occupation (Give kind most of working life, DO NOT use	retired)	
36 nin 72 than " died J	Elementary/Secondary (0-12) College (1-4 or 5+)  10 Car	penter		al Construction
21215-0036 uld be filed within 72 bour Mental Hygiene. marked other than "nate e event, the Medical Exa	17. Father's Name (First, Middle, Last)		ame (First, Middle, Maiden Surname	)
121 d be fill lental l arked event,	Santos Euceda  19a. Informant's Name/Relationship (Type, Print )  19b. Mail		na Manzanares r or Rural Route Number, City or Tow	n, State, Zip Code)
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	Trene Reves (spouse) 61	.03 Amherst Ave,	Springfield, VA	22150
re, N I and Health Fitem	20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  20b. Place of Disposition crematory or	oosition (Name of cemetery, other place)		- City or Town, State
more Pages la nent of He ant: If ite	4 Donation 5 Other Specify: National	CI CIII COI y	7/15/2009 Falls	
Balti	21. Signature of Funeral Service Licensee	2. Name and Address of Facility [	Demaine Funeral H Dad, Springfield,	VA 22151
ysician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter	er the mode of dying, such as card	iac or respiratory arrest, shock, or he	eart Approximate Inter Between Onset a
/Medical	failure. List only one cause on each line.  Immediate Cause (Final disease a Head and Torso Injuries	ag to 1	n =	Death
Examiner	or condition resulting in death)  Due to (or as a consequence of):			
her	Sequentially list conditions, if any, leading to immediate Course			
ted nisit Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			
to, e be executed ysician and burial - transit	d.			
0, e be execut ysician and burial - tra	UNPENDED X AMENDED I tem#1perME, G	893,7/14/09,WS	23d. Date of	of delivery
of Vital Records, P.O. Box 68760, g. Physician: The law requires that the death certificate be executed firer this certificate has been signed by the attending physician and neral director, page 2 should be detached for use as the burial - transi. To Be Completed by Physician/Medical E:	23b. Was decedent pregnant in the	Fetal death 3 Ectopic p	regnancy Month	Day Year
). Box 6876 the death certificate by the attending phyched for use as the Physician/M	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)		
t the de by the ached Phy	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part		atribute to the cause of death?  3 Probably 4 Unknown
ires that the signed by I be detac				. Were autopsy findings avail
Vital Records,   ssician: The law requires his certificate has been sig director, page 2 should be o Be Completed			autopsy performed?	prior to completion of cause death?
Record The la page 2		26.Place of Death (C	1 Yes 2 No	1 Yes 2 No
ital ician: s certif irector, Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpa	Other:		✔ Other: Scene
Division of Vital Records, tal or Attending Physician: The law require as after death.  The Director: After this certificate has been silted in by the funeral director, page 2 should bertification: To Be Completed	1		Passenger auto auto o	urred collision
_ i	Periodic	1,	No	nber or Rural Route Number,
Division of the or Attending and or Attending are after death.  The Director: After a Director: After a Director and the fine of the fine or the fine	3 Suicide 6 Could not be determined (Specify) Interstate/Fynress	street, factory, office building, etc.	or Town, State) Outer Loop of I-95 at Cabi	
	4 Homicide	occurred at the time, date and place	ce, and due to the cause(s) and man	ner as stated.
To the He within 24 To the Fin completed	(Check only one)  2 Certifying Physician: To the best of my knowledge, death of check only one)  2 Medical Examiner: On the basis of examination and/or investand manner stated.	stigation, in my opinion, death occ	urred at the time, date and place, an	gned (Month, Day, Year)
	29b. Signature and title of certifier	29c. License number O.C.M.E.	July 8, 2	
Ψ	30. Name and address of person who completed cause of death (Item 23a)	0.0.111.2.		
OCME	Melissa Brassell, MD Assistant Medical Examiner 1	11 Penn Street, Baltimore	, MD 21201	
	31. Date filed (Month, Day Year) 32. Registrary Signatur			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July Day 2009 Рм Daniel Leslie Malstrom 5:15 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death N/A Overlea Health & Rehab Center Baltimore Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01-21-1939 Min. Months Days Hours 1 X M 2 □ F Maryland 213-40-1467 70 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 □ No Maryland N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21214 U.S.A. 2809 Pinewood Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tes 2 X If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Dependent Dependent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Joseph Malstrom, Sr. Jeannette Trinite 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21214 Mr. Gus Malstrom - Brother 2809 Pinewood Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 07-11-2009 Baltimore, Maryland 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore. Maryland 21214 Mini 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause seach line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

10a State

Director

Funeral

Completed by

Be

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**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Evaninar must be notified at once.

Examiner burial-trai physician Be Completed by Physician/Medical attending properties as Medical Certification: To 24 hours after death.

Funeral Director: After the etely filled in by the funeral

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

that initiated events resulting in death) Last	c	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1	23d. Date of delivery  Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
		1 168 2 2 3 3 6 1 1 1 5 5 5 7 1
		24a. Was an autopsy performed?  1 ☐ Yes 2 ☐ No
25. Was case referred to medical	26 Place of Dec	ath (Check onl one)
examiner? 1 Yes 25 No	Hospital: Other:	Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of /eath   Natural 5 Pending     Accident investigatio	28a. Date of Injury (Month, Day, Year)  28b. Time of Injury Injury  28c. Injury at Work?  1 □ Yes 2 □ No	28d. Describe how injury occurred
3 Suicide 6 Could not b 4 Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) **JUL 13** 

29b. Signature and little of certifier

29a. Certifier

560

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

within 24 hor To the Fune completely fi

### State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name\_(First, Middle, Last) Month **Physician** 7 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number, **Examiner** Samonton mone If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 12-02-1935 6. Sex **Funeral** Min. Months Days Hours 1 □ M 2 🛛 F 219-30-5972 73 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County show r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at Maryland Nottingham Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21236 7414 Virginia Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2X Married 1 ☐ Yes 2 ☐ No 3altimore, Maryland 21215-0036 Specify Specify: \$ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Hygiene. College (1-4or 5+) Homemaker Own Home Ith and Mental Hygie 27 is marked other t r traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Delia Scully Patrick Burke ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Shawn Marvel - Son nt of Health a : If item 27 is or other tra 3403 Royston Avenue Baltimore, Maryland 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department c Important: If any injury or 07/13/2009 Baltimore, Maryland Parkwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature di Funeral Service 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 or complications that seed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on sich line. 23a. Part1. Enter the dise to shock, or heart failur Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical nsequence of): Examiner Sequentially list conditions, If any, leading to immedit cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending phase as the IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) ed by the detached 9 Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 **N**o Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performad? Yes 2 A.No has certificate 1∐ Yes After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P 27. Manner of Peath 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending investigation 1 □ Yes 2 □ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours and To the Funeral Dir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Year

09

N/A

Maryland

U.S.A.

00 P M

9. Birthplace (State or Foreign

10d. Inside City Limits

White

Approximate Interval Between Onset and Death

Day

29d. Date signed (Month, Day, Year)

3 Probably 4 ☐ Unknown

Year

1 ☐Yes 2 🖫 No

State Registrar

ical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Loch Roven Blod.

2009 22162

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	State of Maryland	/ Department of He	eaith and ivieriu	ai myyicii

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historie		distrar Decedent's Name (First, Middle,Lat	st)					1 -	Date of De Month	Day	Year		Time of Death 1600 hrs
al Exami	ner	BERNARD MOORE							July 2, 20	009			10001113
		a. Facility Name (if not institution, gir	ve street and number)		41	o. City, Town, or I	ocation of	Death		4c	. County of	f Death	
		754 Reservoir Street			- 1	Baltimore							
		. Social Security Number 6. S	ex 7. Age	(In yrs. last birti	hday)	If Under 1 Year	If Under	24Hrs.	8. Date of E	Birth (MM/	DD/YYYY)	9. Birthp	place (State or
Funeral	1	Social Security Number		()		Months Days	Hours	Min.			0.51	Foreign Count	try) pc
Director	١.	243.17.8100	(XM 2 F	44	Yrs.			<u>                                       </u>	SEPT	13, 19	964	L	DC
	Ī	Isual Residence of Decedent										1	0d. Inside City Limits
any	Γ	0a. State 10b. County	1	10c. City, Town	or Locatio	on							
d how	_	MD		BALT IMO	RE								1 XX Yes 2 No
Maryland 28a-f show any d at once.	윉	0e. Street and Number				10f. Zip Code				10g. Cit	izen of Wh	nat Countr	у?
or 28	Director		ADT D			21217	,				u	ISA	
with the Maryland ns 23a or 28a-f sho be notified at once.		754 RESERVOIR ST.	12. Was Decedent E	Everin II S	13 W/ss	s Decedent of His		n? (Spec	cify Yes or	No-			an Indian, Black,
W Se	uneral	Marital Status     XXNever Married 2 Marrie	Armod Forces?	Ever in o.s.	If Ye	es, specify Cubar	, Mexican,	Puerto R	ican, etc.)		White	e, etc.	
deatl r ite	틸		1 Yes 2)	XX No							Specify:	R	LACK
after II., c	by F		ed If Yes, Give Year or Dates:			Yes 2XX No		in all of the	rk dono	16h	Kind of Bu		
ours a		15. Decedent's Education (Specify	only highest grade com	pleted) 16a.	Decedent	t's Usual Occupa ost of working life	DO NOT	use retire	d)	100.	Talla of Do		
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Id be filed within fental Hygiene. narked other this	Completed	17. Father's Name (First, Middle, La	st)				18.Mother	s Name (	First, Middl	e, Maide	n Surname	€)	
be file ntal Hy rked o	0	FRANK MOORE						Y TIL					
Mental Filmarked	To B	19a. Informant's Name/Relationship	(Type, Print)	19	9b. Mailing	g Address (Stre	et and Num	ber or Ru	ıral Route I	lumber,	City or Tov	wn, State,	Zip Code)
should be filed within and Mental Hygiene.			SISTER	,	34 NEV	W HOPE ST.	ROANO	KE RA	PIDS.	NC 27	870		
m 2 aur		VENESSA MOORE  20a. Method of Disposition				sition (Name of ce			Date	200	. Location	- City or 7	Town, State
antimore, MD amit. Pages I and 2 shou partment of Health and N portant; If item 27 is niury or other traumatic		1 XXBunal 2 Cremation	3 XXRemoval from Sta			her place)						- 1150	
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permit. Page Department of Important; injury or oth	1 1	21 Signature of Funeral Service Ko	ensee		22 h	Name and Addres	s of Facilit	P.A.	t/a M/	ARYLAI	ND MOR	TUARY	SUPPORT
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ysician	-	23a Part I Enter the disease, or co	mplications that caused	the death. Do r	not enter t	the mode of dying	, such as o	ardiac or	respiratory	arrest, s	hock, or h	eart	Approximate Interva Between Onset and
/Medical		failure. List only one cause on	each line.										Death
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		or condition resulting in death)	Due to (or as a conse	equence or).									
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, be e icia irial	Medical						_		_	- 1	23d. Date	of deliver	у
	Ž	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outco	me or pregnanc	cy Te		Ectop	ic pregna					
760, icate be execut physician and the burial - tra						etal death			incy	- 15	Month		Day Year
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ORIGINAL

		For State of Ma <b>1</b> _ State	•	artment of Health					
		Registrar  1. Decedent's Name (First, Middle, Last)	Ce	ertificate of Deat	tn	2. Date of Death	g. No. 2	009	3. Time of Death
Physic /Medi			William 1	Novak		Month July	Day 9 2	Ye ar 009	1:30 P M
Exami		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location			4c. County		ore Co.
Funeral	۳	1748 Langport Avenue  5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday		der 24 Hrs.	8. Date of Birth		9. Birtho	lace (State or Foreig
Director		213-36-0205 1X M 2 F 7	O Yrs.	Months Days Hour	rs Min.	May 1,	1939	Mar	ÿland
and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation				1	0d. Inside City Limits
Mary a-f sho	ğ	Maryland Baltimore		Dunda1k					1 ☐ Yes 2 📉 No
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ld be f ental ked o	To Be	Frank Novak				Clara 0			
id 2 Ith 8 27 is 27 is tra		19a. Informant's Name/Relationship (Type. Print) Mrs. Carolyn Novak (Wife)	19b. Mai	ling Address (Street and Nu. 1748 Langport	mber or Rura t Ave.	n Route Number, Dundalk	City or Town	ı, State, Zip 7 <b>1an</b> d	21222
ss 1 a of Hei	1 3	20a. Method of Disposition	20b. Place of Disp	position (Name of ematory or other place)	!		0c. Location	- City or To	own, State
Pages ment of ant: If ite	١.	1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State	Sacred H	t. of Jesus (	Cem. 7	/13/2009	Dur	ıda1k,	, Maryland
permit. Pages 1 ar Department of Hea Important: If Item 3 any Injury or other		21. Signature of Funeral Service Licensee	00	22. Name and Address of Ea Duda-Ruck Fi 7922 Wise A	<sup>acility</sup> Ave.	Home of Dundalk,	Dunda Mary1	alk, I and 2	Inc. 21222
Physician /Medical Examiner  by physician and its the prinal-transit	edical Examiner	Sequentially list conditions, if a 1, 1, sealing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of):	toma Ma	Iti fo	(me			Onset and Death,  Smmti
aath certi attending for use a	Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)	-			ate of deliv	rery Day Year
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To the Hospital or within 24 hours afte To the Funeral Dir completely filled in		29a. Certifier (Check only only one)  2 Medical Examiner: On the basis of the basis	f examination and/or	ath occurred at the time, dat investigation, in my opinion,	te and place, , death occur	and due to the cared at the time, da	ause(s) and i ate and place	manner as e, and due t	stated. to the cause(s)
To the within 2 To the I complet	Medical	one) and manner sta  29b. Signature and title of certifier	ated.	29c. License numb	ber , ,	29	9d. Date sign	ned (Mojnth	, Day, Year)
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,		30. Name and address of person who completed cause of d	eath (Item 23a) (Type	e, Print)	3			•	
		AshKan Bahrani	9/14 PI	silade/plice	a Ra	Suite	205	Ba1	to 14cl 213
St Regist	ate	31. Date filed (Month, Day, Year) 32. Registra	ar's Signature	e, Print) Bilade/plice	g Ra	Suite	208	BG 1	to 190

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) рм 2009 6:22 Joseph Bernard O'Donnell, Sr. 08 **Physician** July /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Gilchrist Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept 20 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Year) 1924 Months Days Hours **Funeral** Pennsylvania 1 X M 2 □ F 84 206-14-3841 Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercises. 10c. City, Town or Location 10b. County 10a, State 1 ☐ Yes 2 🕱 No Baltimore Director Md. Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21234 8810 Walther Blvd. #225 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?
1 XYes 2 ☐ No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify: Baltimore, Maryland 21215-0036 White à 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Completed 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Heavy Equipment Elementary/Secondary (0-12) Sales +4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Ellen Brett Bernard Joseph O'Donnell ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 228 Ritterslea Ct. Owings Mills, Md. 21117 Mr. Joseph O'Donnell, Jr./ Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-17-09 Owings Mills, Md. Garrison Forest Va. <sup>22. Name and Address of Facility</sup>
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. 21. Signature of Funeral S ice censee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. rostate Immediate Cause (Final disease or condition resulting in death) MONTH Physician /Medical Duy to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. physician Physician/Medical attending physical for use as the b IF FEMALE: 23d. Date of delivery yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Pregnant at time of death 5 Other (specify) □Yes 2□No ed by the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Monknown <u>ک</u> filled in by the funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy has 2 🗆 No 1 🗌 Yes 1 ☐ Yes certificate 26. Place of Death (Check only one) 25. Was case referred to medical examiner?

1 \( \text{Yes} \) 2 \( \text{D40} \) Be 6 Other (Specify) Other: 4 ☐ Nursing Home 5 ☐ Residence 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Medical Certification: To After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No M investigation after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide determined 4 ☐ Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatuje an

5+1

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

address of person who completed cause of death (Item 23a) (Type, Print)

and of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Payton 7, 3:15 A.M Alvin July 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Takoma Park Washington Adventist Hospital 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea **Funeral** Months Days Hours XXM 2 F 578-70-2451 56 Washington, D.C **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "nature!" any injury or other traumatic excessions. 10b. County 10c. City, Town or Location 10d. Inside City Limits Hyattsville Maryland Prince George's Director XXYes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? U.S.A. 20782 4922 LaSalle Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 Married Black 1 ☐ Yes 2X No If Yes, Give Year or Dates: by 3 Widowed 4XXDivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Unemployed Unemployed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Anthony Payton Virginia G. Watson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valerie Peters (Sister) 11021 Spyglass Hill Mitchellville, Maryland 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Fort Lincoln Cemetery July 11,2009 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marshall's Funeral Home, Inc. 4217 9th Street, N.W. Washington, D.C. mais 20011 23a. Par Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown After this certificate has been signed funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. \$ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐Yes 2 ☐No 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner death 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident s after death 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00060100 07-07-09

Registrar

State

Silver Sp

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alfon Bo

32. Registrar's Signature

AHMINA

31. Date filed (Month, Day, Year)

Registrar

P.O. Box 68760,

of Vital

Division

Registrar's Signature

			For	State of Ma	ryland /						ental Hy	giene	000	0	22	1 6 7
			1 - State Registrar			Cer	titica	e of L	Death		0. Data of D	Reg. No.	<u> </u>	7	O. Time	101
	Physicia	an	1. Decedent's Name (First, Middle, Last,								2. Date of De Month	Day	200	ear	3. Time o	
	/Medic		Nell Roberson Phe						1		July	10	200		9:02	Р "
	Examin	er	4a. Facility Name (If not institution, give		01100			lown, or ckvi]	Location	or Death			County of ntgon			
			Montgomery Hospic  5. Social Security Number 6. Se		(In yrs. last	hirthday)		r 1 Year		24 Hrs.	8. Date of Bi				ace (State	or Foreign
	Funeral Director		579–18–8115	7 to 5 to 5	38	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D November	ay, Year)		Count	try)	J
			Usual Residence of Decedent									,				
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N N	a-f s	cto	Maryland Montgomer	ry	Ro	ockvi	11e									s 2□No
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w dt	23a	ral	710 Roxboro Road						20850				ed St			
ar des	tems er m	Funeral	11. Marital Status	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 🔊 No	ver in U.S.	13. V	Nas Dece f Yes, spe	dent of Hi cify Cuba	spanic Or n, Mexica	rigin? (Spe n, Puerto	cify Yes or N Rican, etc.)	0-	14. Race - Black,	America White, e		
s affe	or i	by F	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ∐Yes 2 ♠ No If Yes, Give Year or Dates:	0	1	I∐Yes	2 <b>X</b> ] No	Specify.	:			Specify:	Whi	tρ	
	tura		15. Decedent's Edu		1	  6a. Deced	dent's Usu	al Occup	ation			16b. Ki	nd of Busin			
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w E	r tha	m <sub>o</sub>	Elementary/Secondary (0-12)	College (1-4or 5+ +2	·)   I	Homem	aker					Own	Home			
illed Z	othe ent,	Be C	17. Father's Name (First, Middle, Last)		•				18. Moth	er's Name	(First, Middle	e, Maiden	Surname)			
g g	Aenta rked tic e	To E	Joseph Oscar Rober	rson, Sr.					Pear	1 Nic	chols					
Short	if Health and Mental Hygiene. item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	_	19a. Informant's Name/Relationship (T)	vpe. Print)							I Route Num					
and 2	n 27 I		Kathryn E. Wilson	/ Daughte	_				Cour		onrovi	·				
ב ב	Department of Health an Important: If item 27 is any injury or other trausone.		20a. Method of Disposition  14 Burial 2 Cremation 3 1	Removal from State	20b. Plac	e of Disponetery, cren onal	sition (Na	me of other plac	e)	July	ate 1 Q	20c. Lo	ocation - Ci	ty or To	wn, State	
Pag Bag	ant: l		4 □ Donation 5 □ Other (Specify,		Nati	Par	k	IIAI		200		Fall	s Chi	irch	, Vir	ginia
	nport ny inj		21. Signature of Funeral Service Licens			R <sub>0</sub> <sup>22</sup>	bert	nd Addre	s of Facil	rey 1	unera:	l Hom	e/Roc	kvi	11e,	Inc.
u a	0 5 5 O		Man J. An		M01360						e,Rockv		Maryla	nd 20		
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused ne cause on each line	the death. I e.	Do not ent	er the mo	de of dyin	g, such as	s cardiac o	or respiratory	arrest,			Approxima Interval Bo Onset and	ate letween d Death
	nysician		Immediate Cause (Final disease or condition	septi	cemia											
,04	Medical xaminer		resulting in death)	Due to (or as a	consequen	nce of):								1		
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, execu	and al-trai	xar	that initiated events resulting in death) Last	c Due to (or as a	a consequen	nce of):										
or ou, ate be executed	ohysician and the burial-transit	dical E		d										1		
ificate	phys s the	edic		d												
ath cert	anding use a	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			7						23d. Date	of delive	ery	
death of	d for	icia	in the past 12 months? 1 ☐ Yes 2 🗓 No	1 ☐ Live birth : 4 ☐ Pregnant at			☐ Ectopic ☐ Other (s	pregnanc pecify) _	У				Mont	h	Day	Year
e e	by the	Physician/Med	9 □ Unknown	9 Unknown												_
S tha	gned e det	by P	Part II. Other significant conditions co	•		ng in the ui	nderlying	cause giv	en in Part	l.	23e. Dio	tobacco	use contrib	ute to th	ne cause of	f death?
ne law requires t	en siç	ed k	Congested	i Heart Fa	ilure						1	Yes 2	□ No 3	☐ Prob	ably 4 💢	Unknown
	s be	Completed	Hypertens	sion							24a. Wa	s an opsy	24b. We	ere auto	psy finding mpletion of	gs available
The T	ate h	mo:									per 1 □Yes	formed?	de	ath?	2 🗆 No	
VIII V	rtifica stor, p	Be	25. Was case referred to medical						26. Plac	e of Death	(Check only					
VSic	direc	2	examiner? 1 ☐ Yes 2 <b>X</b> No	Hospital: 1 ☐ Inpatie	nt 2 EP	R/Outpatier	nt 3 🗆 🛭	Oth Oth	er: 4□ N	lursing Ho	me 5 ☐ Re	sidence	6 <b>X</b> Other	(Specif	y) Hosp	ice
2 4d 5d	fter t	Ë	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		8b. Time of Injury	f	28c. Injur Worl	y at k?		28d. Describe	how inju	ry occurred	i		
VISION	or: A he fu	atic	2 Accident investigation				M		Yes 2							
Y Att	irecto	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc	ry - At home . (Specify)	e, farm, str	eet, facto	ry, office			28f. Location City or T	(Street ar own, State	nd Number e)	or Rura	ıl Route Nu	umber,
<u>֚֓֞</u> ֖֖֜֟֟	ral Di															
Hosp	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as to	edical	(Check only 2 Medical Exam	ysiclan: To the best of Iner: On the basis of	examination	edge, deat n and/or in	h occurre vestigation	d at the ti on, in my c	me, date a opinion, de	and place, eath occur	and due to the red at the time	ne cause(s e, date an	s) and man d place, ar	ner as s id due to	stated.  o the cause	e(s)
÷ e	the the mplet	Med	one)	and manner sta			2	oc Licens	e number			20d Da	ate signed	Month	Day, Year)	)
P	<b>2</b> 00		29b. Signature and title of certifier  J. Ko week	chou,	m	1)	2		63 7				y 12			
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			30. Name and address of person who colorelyne Kouatch					M 111	Road	l. Ro	ckvi11.	о. Ма	יפליטו	nd 2	0855	
	Sta	te	31. Date filed (Month, Day Year)	32. Regis ra	ar's Signatur				Noac	, 10	CKVIII	, 112		<u>.u Z</u>	3000	
	Registr			1 20019 NOV	we	4.	Da	Kel								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death -Month Physician WIN Ju 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** The Johns Hopkins Hospital **Baltimore City**  Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 🕱 M 2 🗆 F 302-48-6846 60 12/10/1948 Missouri Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 28a-f show 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 1 X Yes 2 No Director Camden Cherry Hill NJ 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number U.S.A. 08002 2995 Chapel Avenue West #4Y Funeral 14. Race - American Indian Black, White, etc. Perint. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than """ any injury or other traumation. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces X Yes 2 ☐ No f Yes, Give 1 ☐ Never Married 2 X Married White 1 ☐ Yes 2X No Completed by 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Callege (1-4 or 5+) Military Officer U.S. Navy 12 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Betty Lee Toney Edwin Walter Sroka 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2995 Chapel Avenue West #4Y, Cherry Hill, NJ 21044 Nitalu Sroka/ Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/13/2009 Hanover, Maryland Anatomy Gifts Registry 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Wice Licentee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 65 disease or condition resulting in death) /Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) physician Division of Vital Records, P.O. Box 68760 Physician/Medical the attending 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy Month Dav Year in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 2 No d by the at detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsy certificate has director, page 2 2 🗌 No 2 🗌 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \sum Nursing Home Hospital: 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA မ After this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident eral Director: A after death 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, 4 ☐ Homicide City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

hin 24 hours a the Funeral Completely filled Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2

To the comple 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month. Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

phon

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11 Day 2009 ear Jumph 1:30 P **Physician** John T. Subock /Medical 4a. Facility Name (If not institution, give street and number)
Carroll Hospital Center 4b. City, Town, or Location of Death Examiner Carroll Westminster 8. Date of Birth (Month, Day, Nov 15, Birthplace (State or Foreign Country) M 2□F Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1960 MD 216-80-1181 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits f show 10a. State MD 10b. County Carrol1 ir than "natural", or items 23a or 28a-f shorthe Wedeal Examinar is ust be notified at 1 ☐ Yes 2XXVo Director Finksburg 10g. Citizen of What Country? United States 10f. Zip Code 21048 10e. Street and Number 1198 Marclee Rd. Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married ★ Married 1 □ Yes 2 □ No altimore, Maryland 21215-0036 White If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other traumatic event, the Walter once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sheet Metal Mechanic Metal Work 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Robert L Subock, Sr. Faith A Watts ည 19a. Informant's Name/Relationship (Type. Print) Lisa Subock (wife) 19b. Mailing Address (Street and Number of Rural Route Number, City of Town, State, Zip Code) 1198 Marclee Rd. Finksburg, MD 21048 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Burial 2 Cremation 3 Removal from State 7/15/2009 Sykesville, MD Lake View Mem Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility nurrier-Queen Funeral Home and Crematory, 1212 W. Old Liberty Rd. Winfield, MD 21784 21. Signature of Funeral Service License Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician rla disease or condition resulting in death) /Medical Du to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 3 robably 4 🗌 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To Inpatient 27. Manner of Death 1 D Natural 2 ☐ Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

30. Name and address of person

Registrar's Signature Marked

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12

death (Item 23a) (Type, Print)

29d. Date signed/(Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene

**Physician** /Medical Examiner

**Funeral** Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, Ing Medical Examiner must be notified at 2 should be filed within 72 hand Mental Hygiene.

is marked other than "nate

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau

Physician: The law requires that the death certificate be executed tran and physician a Box 68760, attending ph P.O. ed by the a signed by t Division of Vital Records, cate has been si page 2 should b To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page

Registra

Be

Certification: To

Medical

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 07/07/2009 SPENCER FRANCES 10:00p M 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore na 1911 Riggs Avenue If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country)
 M D Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Days Months 87 215-12-0703 22 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h County 10a State 1 ☑ Yes 2 ☐ No Director Baltimore MD na 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21217 USA Funeral 1911 Riggs Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 ☐ Married BLACK 1 □Yes 2 No Specify: þ 3 ■ Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Domestic worker home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ruth Stewart Clarence Neale 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) MD1216 2309 N. Longwood Street Baltimore, Doris Bowman/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest Vet Owings Mills, MD Funeral Service Licensee 22. Name and Address of Facility 4300 Wabash Avenue March FH West Baltimore, MD 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): 4 MONTHS MYELDID LEUKEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner THROM BO CYTHEMIA Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

Completed

24a, Was an perform 2 No 1 □ Yes 26. Place of Death (Check only one)

28d. Describe how injury occurred

24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No

25. Was case referred to medical examiner' 1 Yes 2 No 27. Manner of Death 1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

5 Pending investigation 6 Could not be determined

Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day, Year)

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

2 ER/Outpatient 3 DOA

28b. Time of

Location (Street and Number or Rural Route Number, City or Town, State)

5 Residence 6 □ Other (Specify)

29b. Signature and title of certifier

BAER, M.R. R.

D0065598

Greene St.

Other: 4 \sum Nursing Home

29d. Date signed (Month, Day, Year) 200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ma

31. Date filed (Month, Day, Year) JUL 13 2009 32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month BETT 0343 Am SMITH 2009 SNUT /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 1 □ F 215-22-2920 1925 Virginia Director Aug. 1, 83 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene, important: If Item 23a or 28a-f show important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Dunda1k Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2804 McComas Ave. 21222 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 **X**No Maryland 21215-0036 1 ☐Yes 2 🗓 No Specify: Specify: Be Completed by XXWidowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Years Homemaker Own Home 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be in nent of Health and Mental Oliver W. Johnson Catherine W. West ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30996 Pine Tree Court Millsboro, DE Catherine L. Affeldt (sister) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corp. 7/10/2009 4 Donation 5 Dother (Specify) Towson, Maryland 21. Signature of Funeral Service License Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Approximate
Interval Between
Onset and Death
YEARS 23a. Art 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ONGESTIVE HEART FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HRONICOBSTRUCTIVE PULMONARY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed burial-transit CARDIGMYGPATHY ISCHEMIC and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Vear Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ pe 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 No 2 No 1 ☐ Yes Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2₩No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Hospital or Attending 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral L Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar

P.O.

Division of Vital

DHMH 17 Rev 1/2001

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Year)

ASHWINI DAVISON

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. 4940 EASTERN AVENUE

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JUNE

BALTIMORE, MD 21224

29, 2009

			For	State of	Maryland		rtment of H		Mental Hy	giene,	2000	2217	1.2
			1 = State Registrar			Cer	tificate of L	Death		Reg. No.	2003	2211	4
	Physicia	an	1. Decedent's Name (First, Middle,	tokes ber	011				2. Date of De	Day	Year	3. Time of Deat 2209 /	
Land.	/Medic	al	Elma S- 4a. Facility Name (If not institution,				4b. City, Town, or	Location of Dear	July		2009 County of Death	22011	
	Examin	er	Harbor Hospita	1	701)		Bultimo						
	Funeral		5. Social Security Number unk	6. Sex 7.	. Age (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs Hours Min	(Month, D	rth ay, Year)	Cou	place (State or For	eign nk
	Director			1 □ M 2 <b>X</b> F	75	Yrs.			Apr 13	, 193	34		
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Loc	cation					10d. Inside City Lin	nits
:	Mary a-f sh ffied a	tor	MD			Ba1	timore					1X Yes 2□	No
:	th the or 284 e noti	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Cou	ntry?	
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1215-0036	urs af al", or	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date		1	□Yes 2XNo	Specify:			Specify: who	ite	
2-C	72 ho natur	Completed	15. Decedent's (Specify only highest	Education grade completed)		(Give	lent's Usual Occupa	luring most of wo	unk unk	16b. Kin	d of Business/Ir	ndustry u	nk
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7	filed within Hyglene. <b>yther than</b> "		17. Father's Name (First, Middle, L				unk	18. Mother's Na	me (First, Middle	e, Maiden S	Surname)	11	nk
<u>a</u>	lid be lental rked o	To Be											
ary	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. If Health and Mental Hygiene a factor of them 23a or 28a-f show fem 21 is marked other than "natural", or items 23a or 28a-f show other traumatic event, I've Modical Examiner must be notified at		19a. Informant's Name/Relationsh	p (Type. Print)		19b. Mailin	g Address (Street a	and Number or F	lural Route Num	ber, City or	Town, State, Zi	p Code)	
χ. Σ	and 2 lealth m 27 I her tra		Harbor Hospita	1	Jan 5		1 S. Hand	over Str		imore	e, MD 2	21225	
Baltimore, Maryland 2	Pages 1 nent of H ant: If ite ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 ☐ Removal from St	ate cei	ace of Dispormetery, cren	sition (Name of natory or other place	e) :	Date	20c. Loc	eation - City or T	own, State	
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	-	-	23a. Rart 1. Enter the disease, or o	complications that cau	used the death.		a <b>ltimore,</b> er the mode of dyin			arrest,		Approximate Interval Between	1
The F	hysician		shock, or heart failure. List o Immediate Cause (Final disease or condition	Thy one cause on each	ho W.	10000	lial Tal	Tarction			- 1	Onset and Death	i
ì	/Medical		resulting in death)	Due to (or	r as a conse rue	ence of):	dial Inf					UNKHOW	n
	Examiner	<u>.</u>	Sequentially list conditions,	b	C V D	ines the							
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Vital Records,	e law re has be je 2 sho	plet							24a. Wa	opsy	24b. Were aut	opsy findings avail ompletion of cause	able of
		Completed by					,		per 1 □ Yes	formed /	l death?	2 □ No	
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ō	ding Physician: The Ih. h. After this certificate he funeral director, page	Certification: To	1 Yes 2 ✓ No 27. Manner of Death	28a. Date of		28b. Time of	1 3 LI DOA	4 LI Nursing	Home 5 ☐ Res 28d. Describe			eify)	
Division of	nding ath. r: Afte e fune	atior	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investiga		, Day, Year)	Injury		<br Yes 2 ☐ No					
<u> </u>	r Atte er deg recto	tific	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ot be ned 28e. Place o building	f Injury - At hon g, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location City or To	(Street and	d Number or Ru	ral Route Number,	
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	To the Hospital or Attending Physician: within 24 hours after death as a first death is certified completely filled in by the funeral director, completely filled in by the funeral director, the filled in by the funeral director, the filled in by the funeral director, the filled in by the funeral director, the filled in by the funeral director, the filled in by the funeral director, the filled in by the funeral director, the filled in by the funeral director, the filled in by the filled in by the funeral director, the filled in by the filled in by the funeral director, the filled in by the funeral director, the filled in by the	edical		Physician: To the bearing: On the base	pest of my know sis of examinati er stated	riedge, deat ion and/or in	n occurred at the tirvestigation, in my o	me, date and pla pinion, death oc	ce, and due to th curred at the time	e cause(s) e, date and	and manner as place, and due	to the cause(s)	
	To the vithin to the To the omple	Med	29b. Signature and title of certifie	and maille	on Stateu.		29c. Licens	e number		29d. Dat	e signed (Month	, Day, Year)	
	->-0		1 ha	X	00		HOC	0649	>	50	142,0	2009	
			30. Name and address of person v	viio completed cause	of death (Item	23a) (Type,	Print)	/			/ -		
			David Scherage	. , Do 300	1 S. Han	court.	29c. Licens HOC Print) St. Balt	imore,	mb 21	225			
	Sta Registr		31. Date filed (Month, Day, Year)	2 A	gistrar's Signati	Loa	Mal						
			JOL I O	UUU MAN		- 1/							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July 8, **Physician** 2009 9:48 AM M Calvester R. Smith /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Towson Gilchrist Hospice If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 26, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. North Carolina 1 🕅 M 2 🗆 F Yrs. 80 107-22-1142 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show "natural", or items 23a or 28a-f sho 1 Yes 2 □ No Director Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 3614 Gwynn Oak Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: black 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) food industry chef 10 t 2 should be filed w th and Mental Hygie 7 is marked other ti 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ev Calvester Smith Kalle Covington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3614 Gwynn Oak Avenue Baltimore, MD Sieglinde M. Stewart/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 N Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street m t1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC PRUSTATE CANCER 2003 /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or selection or of) Examiner the attending physician and hed for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of) 68760 Completed by Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🗆 Ectopic pregnancy Day Month Year 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. funeral director, page 2 should be 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy performed 1 ☐ Yes 2 X No 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) HCSPICE 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. within 2 To the I

Records, Division of Vital

29b. Signature and title of D64395

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701 NORTH CHARLES ST. SUITE 4105 BALTIMORE, MD 21204 DANIEUE DOBERMANIMO

State Registrar

32. Registrar's Signature 31. Date filed (Month, Day, Year) 1 3 2009

**Physician** /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau once.

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

iral", or items 23a or 28a-f show Examiner πust be notified at

Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hyglene.
ant: If item 27 is marked other than "natural", or items 23a or 1 marked other than "natural", or items 23a or 1 mury or other traumatic event, I'm Medical Examinat must hen ury or other traumatic event, I'm Medical Examinat

Baltimore, Maryland 21215-0036

Directo

Funeral

Completed by

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the Maryland

sician and burial-transit attending pl signed by the a certificate has been s rector, page 2 should director this After n 24 hours after death.

Pe Funeral Director: Af bletely filled in by the fur

Division of Vital Records, P.O. Box 68760,

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Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):  C.  Due to (or as a consequence of):			
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4	Part II. Other significant conditions of	contributing to death but not resulting in the underly	ying cause given in Part I.	23e. Did tobacco use contribute t	o the cause of death?
d D	Hypothyroidism	n		1 □ Yes 2X No 3 □ P	robably 4 Unknown
omplete	Hyperlipidemia Gout	a		performed?   death?	utopsy findings available completion of cause of
	25. Was case referred to medical		26. Place of Death	18100	S 2 LINO
Be C	examiner? 1 X Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	1.00	ne 5 Residence 6 Other (Spe	anife)
Medical Certification: To	27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred	еспу)
Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	e 28e. Place of Injury - At home, farm, street, for building, etc. (Specify)	actory, office	28f. Location (Street and Number or Fi City or Town, State)	Bural Route Number,
dical (		nysician: To the best of my knowledge, death occ niner: On the basis of examination end/or investi- and manner stated.			
Š	29b. Signature and title of certifier		29c. License number	29d. Date signed (Mon	ith, Day, Year)

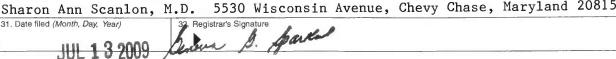
048043

29d. Date signed (Month, Day, Year) July 9, 2009

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)



within 24 hor To the Fune completely f

			State of Maryla	and / Departn				iene	yes yes a manage grown
			For State Registrar		cate of Dea			Ig. No 0 0 9	22175
	Physici	an	1. Decedent's Name (First, Middle, Last)			1	Date of Death Month	h Per Tayean	3. Time of Death
	/Medic	cal	4a. Facility Name (If not institution, give street and number)	4h	. City, Town, or Local		July	4c. County of Death	111-PM
4 13	Examir	ier	Potomar Valley Nursing	Home	Bockvi	112,1	nd	Montgor	nery County
	Funeral		5. Social Security Number 6. Sex 7. Age in y	Mo	Under 1 Year If Un onths Days Hou	nder 24 Hrs. 8. urs Min.	Date of Birth (Month, Day,	Year) 9. Birthp	place (State or Foreign htry)
	Director		578-22-0311 86 Usual Residence of Decedent	Yrs.		Se	ptember	29,1922  Czech	noslovakia
	yland			City, Town or Locatio	n			1	10d. Inside City Limits
	e Mar	Funeral Director	Maryland Montgomery	Bethesda					1 ☐ Yes 2X No
	with th	Dire	10e. Street and Number		0f. Zip Code 2081	1.		Og. Citizen of What Cour Inited State	-
	ns 23	erai	7315 Wisconsin Avenue Suite 7		Decedent of Hispania, specify Cuban, Me			14. Race - Americ	can Indian,
9	or Iter	Fu	1 Never Married 2 Married 1 Yes 2 M No		s, specify Cuban, Me Yes 2 2 No Spe		an, etc.)	Black, White,	
21215-0036	within 72 hours after death with the Maryland ene. than 'natural', or Items 23e or 28e-f show La Mudical Erachi at Linual Le codified at	d by	3 XWidowed 4 Divorced Year or Dates:			ony.			hite
15	in 72 l	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give kind	s Usual Occupation of work done during IOT use retired)	most of working		16b. Kind of Business/In	dustry
212	d with giene.	mo:	Elementary/Secondary (0-12) College (1-4or 5+)	Bookeep	per			Banking	
P	be filed tal Hygi d other event, I	Be C	17. Father's Name (First, Middle, Last)			Mother's Name (F		Maiden Sumame)	
Maryland	should the should the	2	Hyman Borochowitz	10h Mailian As		Ella Gold		, City or Town, State, Zip	Codal
Mai	01 00 00 00	1 1	19a. Informant's Name/Relationship (Type, Print)  Bernard Forseter/Attorney	-				t,Bethesda,	
re,			20a. Method of Disposition 20th	b. Place of Disposition cemetery, cremator	n (Name of	Date		20c. Location - City or To	
imo	nit. Pages artment of ortant: If it Injury or o		1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State M 4 ☐ Donation 5 ☐ Other (Specify)	lontgomery rematorium	n. Inc.	July 1		Bethesda, Ma	aryland
Baltimore,	permit. Page Department o Important: If eny Injury or once.		21. Signature of Funeral Service Licensee	Robe:	me and Address of F	rey Funeral Avenue, Be	L Home/B thesda,	ethesda-Chevy Maryland 2081	Chase, Inc. 14-3501
	A ST		23a. Part1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line.						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	umani	2			3	dau S
1	/Medical Examiner	П	resulting in death)  Due to or as a cons	sequence of):					93
		ē	Sequentially list conditions, if any, leading to immediate Due to (or as a cons	sequence of):					
	cuted nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause, Usade of in u y that initiated events c.						
760,	te be executed ysician and e burial-transit	EX	resulting in death) Last Due to (or as a cons	sequence of):					
687	<u> </u>	dicai	d						
Box (	eath certificate attending physical for use as the l	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pre					23d. Date of deliv	ery
W.	the atte	sicia	in the past 12 months?  1 Yes 2 No 4 Pregnant at time of		opic pregnancy ner (specify)			Month	Day Year
P.0	that the died by the detached	Phy	9 Unknown  Part II. Other significant conditions contributing to death but not	regulting in the under	hina agusa ayan in l	Post	23a Did tob	pacco use contribute to t	the cause of death?
Vital Records,	ulres t signe	d by	Denentia	resulting at the under	iyili <b>g cacse</b> gi <del>ro</del> zi iil i	art.	1 □ Y€		bably 4 □Unknown
Š	w requir s been si should	iete		Thrive			24a. Wasa	n 24b. Were auto	opsy findings available
Re	The lav	Completed					autops perform 1 Yes 2	ned? death?	ompletion of cause of
/ita	ysician: The is certificate hi director, page	Be	25. Was case referred to medical examiner?			Place of Death (C			
of \	Physi this c	2			DOA Dthen: 4			ence 6 Other (Speci	fy)
on	th. : After s fune	tion	27. Manner of Death  1 Inatural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year		Work? I ☐ Yes		. 50301150 110	on analy coodined	
Division	ar dearector	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - A building, etc. (Sp.	At home, farm, street,	factory, office	28f.	Location (St City or Town	reet and Number or Run n. State)	al Route Number,
Ö	ital or ira aft iral Di		, pure practi	tioner					
	To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier (Check only one)  1 Certifying Physiciem: To the best of my 2 Medical Examiner: On the basis of exam and manner stated.	nination and/or investi-	gation, in my opinion	, death occurred	at the time, di	ate and place, and due t	to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	Clu-	29c. License num	aber 3 a 7 1	2	9d. Date signed (Month,	Day, Year)
			y rung Taynos,	(ho= 02:) 7	1211.	171		DACTER	12 MA
			and manner stated.  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (  MA/2 HAYNUS  31. Date filed (Month, Day, Year)  JUL 13 2009  22. Registrar's Si	P IDII	Mulecu	I AND DR	2#20	11 208	50
	Sta Regist	ate rar	JUL 1 3 2009	gngure gark					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death .Month **Physician** 6:30pM VAYNEROVSKAYA 7009 SONYA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORE SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 04/25/1936 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months 1 □ M 2 🕽 F 73 UKRAINE 213-35-5343 **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State items 23a or 28a-f show 1 □Yes 2X No Director BALTIMORE REISTERSTOWN 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number death with Funeral 306 CANTATA COURT, CONDO 420 21136 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married th and Mental Hygiene.
77 is marked other than "natural", or traumatic event, the Madical Ever. Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: WHITE þ 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **BOOKKEEPER** GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BENNETT **FELDSHER** BELLA ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health of Hem 27 is Department of Health Important: if Item 27 any injury or other troonce. ELLA STERN / DAUGHTER 310 BONNIE MEADOW CIR., REISTERSTOWN, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State BALTIMORE HEBREW 07/10/2009 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21208 RD., PIKESVILLE, MD 8900 REISTERSTOWN 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician Due to (or as a sequence of): disease or condition resulting in death) /Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or a a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋧ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Other: 4 Nursing Home 5 Residence 6 A Other (Specify) No. 1705 PICE Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation i Director: Ald in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) by 4 Homicide filled in 24 hours a Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 ho

To the Fune

completely f and manner stated.

State Registrar

29b. Signature and title of certified

31. Date filed (Month, Day,

Burton

30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

H45931

2835 Smith Avenue Suite 200 Baltimore MD

29d. Date signed (Month, Day, Year)

ノ v	
Sta Registr	
DHMH 17 Rev 1/2	001

an	1 - For State Registrar	•	and / Depa <i>Cei</i>	rtificate of	Death		Reg. No.		
ш	1. Decedent's Name (First, Middle, Last	)		•	:	2. Date of De	ath Day	Year	3. Time of Death
al	Clarenc	ce l	Williar	ns		July	08	, 2009	1:40P M
er	4a. Facility Name (If not institution, give		" <b></b>		Location of Death		4c. 0	County of Death	
	501 Dolphin St 5. Social Security Number 6. Se		#511 rrs. last birthday)	Baltimo		R Date of Bir	th	NA 9 Birthr	lace (State or Foreigi
		M 2□F 61	Yrs.	Months Days	Hours Min.	3. Date of Bir (Month, Da )1 - 21 -	y, Yea <i>r</i> ) -48	Cour MD	itry)
	Usual Residence of Decedent				1 1	, 1 2 1	70		
	10a. State 10b. County		City, Town or Lo					1	0d. Inside City Limits XX☐Yes 2☐No
;	MD NA		Baltimo				40. 0		
Disector	10e. Street and Number 501 Dolphine S	Stroot Ant	#511	10f. Zip Code	217		10g. Citiz	en of What Cour	try?
	11. Marital Status	12. Was Decedent Ever in			lispanic Origin? (Spec	ifv Yes or No	- 1	4. Race - Americ	an Indian
	1 Never Married 2 Married	Armed Forces? 1 ∐Yes ※∏No	'	If Yes, specify Cuba	an, Mexican, Puerto R	ican, etc.)		Black, White,	cican
	3 ☐ Widowed 4 ☐ Divorced	lf Yes, Give <sup>™</sup> Year or Dates:		t⊡Yes 2∭XNo	Specify:			Specify:	cican
	15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a. Dece	dent's Usual Occup	ation during most of working	,	16b. Kin	d of Business/Inc	dustry
non-landing of	Elementary/Secondary (0-12) 9th Grade	College (1-4or 5+)	life. I	DO NOT use retired	1)		m	1 .	2
	17. Father's Name (First, Middle, Last)	IVA	Driv	ver	18. Mother's Name	First Middle			Company
		Williams			Emma	r not, madic,		yer	
	Ernest  19a. Informant's Name/Relationship (7)		19b. Mailir	ng Address (Street	and Number or Rural	Route Numb			Code)
	Ruth Mary Wil				Avenue Ba				
1	20a. Method of Disposition	208	b. Place of Dispo	sition (Name of natory or other plac	Da Da	te	20c. Loc	cation - City or To	wn, State
	1	Removal from State			ery 07-14	-09	Lan	sdowne	, MD
	21. Signature of Funeral Service Licens		22	2. Name and Addre	ss of Facility $Wv1$	ie Fui	nera	1 Home	P.A.
	Jumela	Waries	)  6.	38 N. G	ilmor Šti	reet	Balt	ımore,	MD 2121
	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the dene cause on each line.	eath. Do not ent	er the mode of dyir	ng, such as cardiac or	respiratory a	rrest,		Approximate Interval Between
ı	Immediate Cause (Final disease or condition	MYOCAR	DIAL	LNFARC	TION ,	ROBA	BL	E	Onset and Death
	resulting in death)	Due to (or as a cons	sequence of):	223	^ -				
,	Sequentially list conditions,	b. A lue to (or as a cons	CLETZ	OTHIC	HEARI	10156	-A-S-1	5	20 YRS
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (of as a cons	sequence on.						
	that initiated events resulting in death) Last	c Due to (or as a cons	sequence of):						
alca.		d.							
- 1		<u> </u>							
	23b. was decedent pregnant	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F		☐ Ectopic pregnanc	v		2	3d. Date of delive	
2	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at time of		Other (specify)	,			Month	Day Year
J	9 Unknown		requities to the	adarluir ·	on in Do-t	220 Dist	obacca	o contribute to the	no cause of death?
/ Pnysician/m	Part II. Other significant conditions co	PANCIDEA	TO 1	nuenying cause giv	en in Part I.	23e. Did t		se contribute to ti	ne cause of death? Dably 4 ☐ Unknow
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fa non-d	DIABETE:	5 MELL	1105			autoj perfo 1 □ Yes	osy ormed? 2 No		mpletion of cause o
	25. Was case referred to medical examiner?	Hospital:	1105	Oth	26. Place of Death	autoperfo	osy ormed? 2 DNo one)	prior to co death? 1 □ Yes	mpletion of cause o
	examiner?	Hospital: 1   Inpatient 2   28a. Date of Injury	ER/Outpatier		er: 4 🗆 Nursing Hom	auto perfo 1 □ Yes (Check only o	ory ormed? 2 ( No one) dence 6	prior to co death? 1 ☐ Yes	mpletion of cause o
fa posidillos se si	examiner? 1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day, Year,	28b. Time of	f 28c. Injur Wor	er: 4 ☐ Nursing Hom	autoperfo	ory ormed? 2 ( No one) dence 6	prior to co death? 1 ☐ Yes	mpletion of cause o
fa posidillos se si	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending Investigation  3 Suicide 6 Could not be	28a. Date of Injury (Month, Day, Year)  28e. Place of Injury A	28b. Time of Injury	f 28c. Injur Wor M 1	er: 4 Nursing Hom y at 25 K? Yes 2 No	autoperformation in the second	one) dence 6 how injury	prior to co death? 1 ☐ Yes	mpletion of cause o 2 □ No 'y)
	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day, Year	28b. Time of Injury	f 28c. Injur Wor M 1	er: 4 Nursing Hom y at 25 K? Yes 2 No	auto perfo 1 □Yes (Check only on e 5 □ Resi ad. Describe	one) dence 6 how injury	prior to co death? 1 □ Yes □ Other (Specificoccurred	(y)
cel unication. To be completed by	examiner?  1 Yes 2 No  27. Manner of Death 1 Notural 5 Pending Investigation 3 Suicide 6 Could not be determined  29a. Certifier 1 CertifyIng Phy	28a. Date of Injury (Month, Day, Year)  28e. Place of Injury A	28b. Time of Injury  t home, farm, strecify)	f 28c. Injur Wor M 1 = eet, factory, office	er: 4 Nursing Hom y at 2t k? Yes 2 No 2t me, date and place, a	autoperfor  1   Yes  Check only of  e 5   Resi  3d. Describe  3f. Location (  City or Total	psy primed? 2 (No one) dence 6 how injury Street and wn, State) cause(s)	prior to co death? 1 □ Yes  □ Other (Special occurred	mpletion of cause o 2 \( \sum No \)  (y)  al Route Number,
certification: 10 be completed by	examiner?  1 Yes 2 No  27. Manner of Death  1 Notural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only 2 Medical Exam	28a. Date of Injury (Month, Day, Year)  28e. Place of Injury - A building, etc. (Specials: To the best of my liner: On the basis of examples)	28b. Time of Injury  t home, farm, strecify)	f 28c. Injur Wor M 1 = eet, factory, office	er: 4  Nursing Hom y at Yes 2 No  me, date and place, a pinion, death occurre	autoperfor  1   Yes  Check only of  e 5   Resi  3d. Describe  3f. Location (  City or Total	psy promed? 2 (No pine) dence 6 how injury Street and wm, State) cause(s) date and	prior to co death? 1 □ Yes  □ Other (Special occurred	mpletion of cause o  2 No  y)  No  Route Number,  stated.  b the cause(s)
certification: 10 be completed by	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined  29a. Certifier (Check only one)  1 Certifying Phyone	28a. Date of Injury (Month, Day, Year)  28e. Place of Injury - A building, etc. (Specials: To the basis of examand manner stated.	28b. Time of Injury  It home, farm, streedfy)  knowledge, deatt innation and/or in	f 28c. Injur Wor M 1 = 28c. Injur Wor wor 1 = 28c. Injur Wor 1 = 28c.	er: 4  Nursing Hom y at Yes 2 No  me, date and place, a pinion, death occurre	autoperfor  1   Yes  Check only of  e 5   Resi  3d. Describe  3f. Location (  City or Total	psy promed? 2 (No pine) dence 6 how injury Street and wm, State) cause(s) date and	prior to co death? 1  Yes  Other (Specifi occurred	mpletion of cause of 2 No 2 No  y)  al Route Number,  stated. b the cause(s)
Medical Certification: To be Completed by Phy	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined  29a. Certifier (Check only one)  29b. Signature and title of certifich  30. Name and address of person who could be determined	28a. Date of Injury (Month, Day, Year)  28e. Place of Injury - A building, etc. (Specials: To the best of my liner: On the basis of examand manner stated.  Ompleted cause of death (1)  32. Registrate Signature (1)	t home, farm, streedify)  knowledge, death innation and/or in term 23e) (Type.	f 28c. Injur Wor M 1 = 28c. Injur Wor wor 1 = 28c. Injur Wor 1 = 28c.	er: 4  Nursing Hom y at Yes 2 No  me, date and place, a pinion, death occurre	autoperfor  1   Yes  Check only of  e 5   Resi  3d. Describe  3f. Location (  City or Total	psy promed? 2 (No pine) dence 6 how injury Street and wm, State) cause(s) date and	prior to co death? 1  Yes  Other (Specifi occurred	mpletion of cause of 2 No 2 No  y)  al Route Number,  stated. b the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) <sup>™</sup>2009 July 11, 3:01 p M Helen. Wong 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Silver Spring Holy Cross Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 0Ct 4, 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Min 1 □ M 2 □ ¥ Wash., D.C. 79 577-52-2541 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2√ No MD Silver Spring Montgomery 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20904 3144 Gracefield Rd., Apt., T-18 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 XMarried 1 ☐ Yes 2 ☐ No Specify Asian 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lee Τον Fong Shee 1 66 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 305 Irene Way, Stevensville, MD Jeffrey Wong-son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 7/18/09 Dulanev Valley Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee Dau 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

show

'natural', or items 23a or 28a-f sh dicel Examiner must be notified

nd 2 should be filed within 72 hou alth and Mental Hygiene. 27 is marked other than "natura ir traumatic event, it in Medicit E

Health a

permit. Pages 1 and:
Department of Health
Important: If item 27
any Injury or other tr

Director

Funeral

2

Completed

Be

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filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

sician and burial-trans attending pl signed by 1 I be detach

law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner

ģ

Be Completed

Certification: To

29b. Signature and title of certifier

SUGANTHI 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

e Hospital or Attending Physician: The 24 hours after death.
2e hours after death.
a Funeral Director: After this certificate hieletly filled in by the funeral director, page

Immediate Cause (Final disease or condition resulting in death)	a. ACUTE RESPIRATORY FRITURE  Due to (or as a consequence of):  PNEUMONIR AND CHE	
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. NEW ONSET ATRIAL FIBRILL  Due to (or as a consequence of):  d	LATION
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions co	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 凝 Unknow
		24a. Was an autopsy performed?  1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No
25. Was case referred to medical	26. Place of Deat	h (Check only one)
examiner? 1 ☐ Yes 2 ♣No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	ome 5 ☐ Residence 6 ☐ Other (Specify)
27. Manner of Death  1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier  (Check only  2 Medical Exam	<ul> <li>ysician: To the best of my knowledge, death occurred at the time, date and place inner: On the basis of examination and/or investigation, in my opinion, death occur</li> </ul>	, and due to the cause(s) and manner as stated. rred at the time, date and place, and due to the cause(s)

29c. License number

DO06 7279

FOREST GLEN PLA SIEUSE SPRING, MI

29d Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

within 2

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1 9

			State Registrar			Cei	rtificate of	Death		Reg. I	No.2 ()	09	22	179
	Physicia		1. Decedent's Name (First, Middle, Las	Leo	ta		Wilson		2. Date Mont Jul		Day . O , 2	Year 2009	3. Time of 5:45	
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town,	or Location of			4c. County	of Death		
	LXaIIIII	51	Stella Maris Ho	spice Ctr			Timo	nium			Balt		e Co.	
()	Funeral		Social Security Number 6. S	x 7. Age		s. last birthday)   If Under 1 Year   If Under 24 Hrs.   8. Date of Birth (Month, Day, Year Min.   March 6,					ar)	Coun	lace (State o	r Foreign
	Director		218-22-4421	□M 2\\ F 8	2	Yrs.	Months Days	Tiodis	Marc	h 6,	1927	Ken	túcky	
2	P.		Usual Residence of Decedent		10 0"	~ .1.							0d. Inside Cit	ty Limite
18	urylar show	_	10a. State 10b. County		Tuc. City	, Town or Lo						"	1 ☐ Yes	
Sitsam	8a-f	ctc		ltimore			Dunda	ılk		1.0	Citizen of V	N" - 1 O		
in	or 2	Director	10e. Street and Number	,			10f. Zip Code	212	222		United			
7)	ath v	ral	2423 Meadow Road		5to 11.6	140.	Man Danadant of					e - Americ		
_	er de	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		5. 13.	ras Decedent of f Yes, specify Cul	ban, Mexican	gin? (Specify Yes , Puerto Rican, et	or No- c.)	Blac	ck, White,	ari indian, etc.	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	1 ∐Yes 2 ⊠ N If Yes, Give Year or Dates:	40		1∐Yes 21XTNo	Specify:			Specify	′: W	hite	
2009	within 72 hours after death with the Maryland iene. than "natural", or items 23a or 28a-f show he Medical Evaruinar roust by nouthed at	ed	15. Decedent's Ed			16a. Dece	dent's Usual Occu	pation		16b	. Kind of Bu	usiness/Ind	dustry	
25	in 72 in "in	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed)  College (1-4or 5-	+)	(Give life.	kind of work done DO NOT use retire	e during most ed)	of working					
21;	d with giene	No.	8 Years		<u>'</u>	Hom	emaker				Own	n Hom	.e	
○ <u>P</u>	al Hy roth	Be (	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name (First, N		len Surnam	ne)		
la l	uld b Ment arked	70	David Day, Sr	•					Ethel I	Hall				
4 (0) 2009 Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evarumer must be rectified at once.		19a. Informant's Name/Relationship (7 Arthur T. Wilson		1)	1	ng Address <i>(Stree</i> Cherlyr		Essex,			State, Zip 2122		
Jul altimore,	s 1 a of Hear item		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of natory or other pla	ace)	Date	20c	Location -	City or To	wn, State	
₩ E	Page nent ( int: If		P☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		- 1		f Faith		7/13/200	09 1	Baltir	more,	Mary1	Land
alti	mit. partn porta y Inju		21. Signature of Funeral Service Licen	Hee )	10	2	2. Name and Add	ress of Facility	ral Home	of D	undall	k. In	c.	
Ω	8 8 E 8 8		1 2 (	. ( e	4	/ 17	922 Wise	e Ave.	Dundall	Ma:	ryland			
			23a Part 1 Enter the disease, or comp shock, or heart failure. List only	lications that caused	the death	. Do not en	er the mode of dy	ing, such as	cardiac or respira	tory arrest,			Approximate Interval Bet	e ween
	Physician		Immediate Cause (Final	END	STA	GE	RENA	( )	ISCASE	=			Onset and I	Death
	/Medical		resulting in death)	ue to (or as	a consequ	uence of):								
	Examiner	,	Sequentially list conditions,	b										
	D #	Examiner	if any, leading to ininegiate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a eu leequ	ianoa J):								
	ertificate be executed ling physician and e as the burial-transit	xam	that initiated events resulting in death) Last	cDue to (or as a	a consequ	ience of):								_
} 68760,	be ey ician burial			500 10 (01 25 1	a 00110040	201100 017.								
789	phys the	Medical		.d										
/ ×	certif iding se as		IF FEMALE:	23c. If yes, outcome	of pregna	псу					23d Da	te of delive	erv	
DO C	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	by Physician	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	death 3	☐ Ectopic pregnar ☐ Other (specify)					onth		Year
NO.	the d y the iched	ıysi	1 ☐ Yes 2 No 9 ☐ Unknown	9 Unknown										
7	that ned b	y P	Part II. Other significant conditions of	ontributing to death b	ut not resu	ılting in the u	nderlying cause g	jiven in Part I.	23e	Did tobac	co use conf	tribute to t	he cause of o	?dtset
_⊰ રૄ	quires	q p								1 ☐ Yes	2 <b>X</b> No	3☐ Prol	babiy 4□	Unknown
A V	w rec	lete							24a	. Was an	24b.	Were auto	psy findings	availabje
A ag	ifcian: The lav certificate has rector, page 2 a	Completed	<del> · ·</del>						_	autopsy performed Yes 2	<b>)</b> ?	prior to co death? 1  Yes	mpletion of o	ause or
ta	an: Tifica tor, p	Be C	25. Was case referred to medical					26. Place	of Death (Check		410	1 🗆 103	20110	
₩ <sub>≥</sub>	Physician: The law this certificate has traidirector, page 2 sl		examiner? 1 ☐ Yes 2 No	Hospital:	ent 2 🗆	ER/Outpatie	nt 3□ DOA O	ther: 4 🗆 Nu	ursing Home 5 □	] Residenc	e 6 Cott	ner <i>(Speci</i> i	MUSP	ICE
70	ulng Phys n. After this funeral di	T:u	27. Manner of Death	28a. Date of Inju	ıry ıv. Year)	28b. Time of Injury	f 28c. Inj	jury at	28d. Des	cribe how i	injury occur	red		
. <u>ö</u>	Attending r death. ector: After	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			□Yes 2□	No				-	
Division	r Atte	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ury - At ho	ome, farm, st	reet, factory, office	9	28f. Loca City	tion <i>(Stre</i> e or Town, S	t and Numb tate)	ber or Run	al Route Nun	nber,
	ital or urs afte ral Dir lled in													
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ht completely filled in by the funeral director, page	Medical	(Check only •2 Modical Evan	ysician: To the best niner. On the basis o	f avamina	wledge, deal tion and/or in	in occurred at the ivestigation, in my	time, date ar y opinion, dea	nu place, and due ath occurred at the	to the caus time, date	e(s) and m and place,	and due t	o the cause(	s)
	the the make	Med	29b. Signature and title of certifier	and manner sta	ateu.		29c. Lice	nse number		29d.	Date signe	ed (Month,	Day, Year)	
	vit vit		A Llas	201010			D	140-10	7		Mli	1200	9	
			30. Name and a view of pilison who	COUT completed cause of d	leath (Ita-	23a) (Tuno	Print)	1717	-		1110	1200	/	
1			TACKIE TINES C	WA 72	N D	1/ANA	CY 1/A/11	CY RO	> TIMON	11414	1. M.	2	1093	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signa	ture	U V				1			
-4.	Dogiete	0.	1111 4 6		200	AND LAPA AR	Prof.							

			For State	State of Mai	ryland		rtment of h tificate of			giene Reg. No. 🤈	000	22100
		·	Registrar  1. Decedent's Name (First, Middle, Last)	)					2. Date of Dea	ath	UUJ	3. Time of Death
	Physicia		Norman Edward Wr						July	$11^{Day}$	2009	2:15 A M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)				or Location of Deat	h		inty of Death	
APT)			Shady Grove Adven				Rockvi If Under 1 Year	11e If Under 24 Hrs	l o Data at Dist		tgome	
	Funeral		5. Social Security Number 6. Security Number 12	ČM 2□E	(In yrs. la:	st birthday) _ Yrs.	Months Days	Hours Min.		y, Year) <b>24 1912</b>		nplace (State or Foreign Intry) 7and
	Director		Usual Residence of Decedent		<i>31</i>				rebluary	2791712		
	ryland how		10a. State 10b. County		10c. City,	Town or Loc	ation					10d. Inside City Limits 1X Yes 2 □ No
	8a-fs	ecto	Maryland Montgom	ery	Ro	ckvill				10g. Citizen	of What Cou	
	with the	Ö	10e. Street and Number				10f. Zip Code	0850		United		
	ns 23	Funeral Directo	8 Baltimore Road	12. Was Decedent Ev	ver in U.S.	. 13. W		Hispanic Origin? (S ean, Mexican, Puer			Race - Amer	rican Indian,
9	after o		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give	0		Yes, specify Cub □Yes 2 <b>1</b> 2 No		to Rican, etc.)		Black, White	
21215-0036	within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show the Model Even in a rout be neithed a	d by	3 X Widowed 4 ☐ Divorced	Year or Dates:						15 20 250	ecify: Wh	
2-	"natı	lete	15. Decedent's Edu (Specify only highest grad	cation e completed)		16a. Decede (Give k	ent's Usual Occu ind of work done O NOT use retire	pation during most of wo ed)	rking	16b. King (	of Business/li	ndustry
12	withir iene. • than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+			intenden			Federa	al Gov	ernment
Ö	al Hygi other	Be C	17. Father's Name (First, Middle, Last)			•		18. Mother's Na	me (First, Middle,		name)	-
ylar	2 should be filed within 72 hours after death with the Marylan and Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f show at marked other than "natural", or items 23a or 28a-f show aumatic event, the Madoal Evander.	To E	Claude Wright						Stottle			
Maryland	2 sho n and is ma		19a. Informant's Name/Relationship (7)					t and Number or R				
e,	1 and Health sm 27 ther t	1	Patsy W. Elder /	Daughter	20b Pla			Drive, G	Date		on - City or T	
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev once.		1 🔀 Burial 2 🗆 Cremation 3 🗆 F		C1a	metery, crem rksbur	ition (Name of atory or other pla g Method	$\inf_{\mathbf{j}\in J} July$	y 15, 2009	Cl amb		Maryland
量	artme ortan injur		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licens		Cnu		metery Name and Addr				COOK THE CONTRACTOR	ville, Inc.
ä	Imp any onc		I That I for		MO 1	360	00 West Mo	ntgomery A	venue, Rock	cville,	aryland	20850-2805
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused ne cause on each line	the death. e.	Do not ente	r the mode of dy	ing, such as cardia	ac or respiratory a	ırrest,		Approximate Interval Between
4	Physician	î l	Immediate Cause (Final disease or condition	нурох н							]	Onset and Death Minutes
	/Medical Examiner		resulting in death)	Due to (or as a		ence of):						Dove
		-E	Sequentially list conditions,	b. Sepsi:		ence of):						Days
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Arrhy	1.5						į.	Minutes
oʻ	e exec an an rial-tra		resulting in death) Last	Due to (or as a			-					
68760,	ficate be executed physician and s the burial-transit	edical		d. Coron	ary A	Artery	Disease		····			
	certific ding p		IF FEMALE:	23c. If yes, outcome of	of pregnan	ncv				220	. Date of del	ivery
Вох	leath certifi attending for use as	Physician/M	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at	2 🗌 Fetal	death 3 🗆	Ectopic pregnan Other (specify)			200	Month	Day Year
P. O.	at the de by the stached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown								
	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	by P	Part II. Other significant conditions co	ntributing to death bu	ıt not resul	Iting in the un	derlying cause gi	iven in Part I.				the cause of death?
Records,	w require s been si should t								1 📗	Yes 2.	No 3∐ Pi	robably 4 Unknown
Sec	e law r has be	Completed							24a. Was		24b. Were au prior to death?	utopsy findings available completion of cause of
ᄪ									1 ☐ Yes	2 <b>X</b> No		2 □No
Ħ	<b>hysician:</b> The Ir his certificate ha I director, page 2	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 🏋 No	Hospital:	O	ER/Outpatien	+ 2 DOA 01	ther:	eath (Check only Home 5 ☐ Res		Other (See	noifis)
o	ding Phy:	i.To	27. Manner of Death	28a. Date of Injur	ry	28b. Time of	28c. Inji		28d. Describe			City)
Division of Vital	ath. r: Afte	Certification: To	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	y, year)	Injury		∃Yes 2 □No				
<u>≥</u>	or Attendatter death Director;	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc	ry - At hor . (Specify	me, farm, stre	et, factory, office			(Street and N wn, State)	lumber or Ri	ural Route Number,
	ospital o hours af uneral Di		CO- Contiller 4 1 Contiller Di	- I - I - I - I - I - I - I - I - I - I	-6 may 1 lan av	uladas dast	a account of the	time data and pla	oo, and due to the	0 031168(6) 31	nd manner a	s stated
	# 24 E e e	Medical	29a. Certifier 1 To Certifying Phy (Check only 2 Medical Examone)	ysician: To the best on hiner: On the basis of and manner sta	f examinat	ion and/or in	vestigation, in my	opinion, death oc	curred at the time	, date and pl	ace, and due	e to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier					nse number		29d. Date s	signed (Mont	th, Day, Year)
			1 Astanho	ised,	IM		MI	D55	054	July	11, 2	009
			30. Name and address of person who					/00 a :	. 1 1	M	1 1	20977
			Attan Kasid, M.D.  31. Date filed (Month, Day, Year)					409 Gai	tnersbur	g, Mai	yrand	200//
	Sta	ite	IIII 1 3 2000	32. Registra	1	we har	Kel					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2:20 AM Eugene June 2009 avid /Medical 4c. County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown 9. Birthplace (State or Foreign Country) West Virginia If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1928 West 236-40-8621 81 June Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 □Yes 2 No Director Boonsboro Washington Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code **USA** 21713 6527 King Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 1952- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1954 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Gas Station Operator 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Roop William E. Allen Mary ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21795 11038 Hickory School Road Williamsport, MD Debbie R. Beall / Daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 6-30-2009 |Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory Bast-Stauffer Funeral Home, P.A. 7606 Old National Pike Boonsboro, MD 23a. Part 1. Phiter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death troke Immediate Cause (Final 24 hours **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): buriat Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) n signed by the a 1 ☐ Yes 2 ☐ No o 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 3 Probably 4 Unknown 1 Tes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed Yes 2 certificate 1 ☐Yes 1 □Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 ER/Outpatient 3 DOA 1 Tes 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) Manner of Death 28c. Injury at Work? Division Hospital or Attending 1 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Umbedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Cur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M-P

32. Registrar's Signature

12821

**ORIGINAL** 

Registrar

9

31. Date filed (Month, Day, Year)

			Type or Print State of Mary					=		gible.	_
	1	For State Registrar			Certific	ate of	Death	R	eg. No. 🥎	nne	22182
Physicia /Medica		Decedent's Name (First, Middle, Las ERNESTINE						2. Date of Dea Month JUNE	Day	2009 2009	3. Time of Death 12:00 P M
Examine	_	4a. Facility Name (If not institution, give			4b. 0	-	or Location of Death	1	4c. Cour	ity of Death	
		GILCHRIST HOSPIC  5. Social Security Number 6. S		n yrs. last birti	hday) If U	nder 1 Year	TOWSON  If Under 24 Hrs.	8 Date of Birth		BALTII	MORE place (State or Foreign
Funeral Director		218–72–3494			rs. Mon			8. Date of Birth (Month, Day MAY 24,	<sup>Year)</sup> 1950	Cou	ntry) \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
/land	}	Usual Residence of Decedent  10a. State 10b. County	10	Oc. City, Town	or Location						10d. Inside City Limits
e Mary	cto	MARYLAND HA	RFORD			ABE	ERDEEN				1 XYes 2 □ No
with the	Director	10e. Street and Number 80 E. BEL AIR AV	ENUE, APT B	7	10f	. Zip Code	21001		0g. Citizen o	of What Cou	
ms 23	Funeral	11. Marital Status	12. Was Decedent Eve		13. Was D		Hispanic Origin? (S pan, Mexican, Puert	pecify Yes or No-	14. F	lace - Amer	ican Indian,
Irs a	2	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1			specify Cub		o Micari, etc.)		lack, White,	
72 ho	eted	15. Decedent's Ed (Specify only highest gra	lucation de completed)		Decedent's (Give kind o	f work done	during most of wor	king	16b. Kind of	Business/Ir	ndustry
within ene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NO	OT use retire BABYSI			(	OWN HO	ME
e filed Il Hygi other rent, I	Se P	17. Father's Name (First, Middle, Last)					18. Mother's Nan	ne (First, Middle,	Maiden Surn	ame)	
Menta Menta arked atic ev	0	JAMES AKINS					DORA PRE	ESBERRY			
and 2 sho ealth and n 27 Is me		19a. Informant's Name/Relationship ( TRASHEL M. MAYE	•	l _	_		R AVENUE		-		
es 1 a of Head of Head fitem or other		20a. Method of Disposition 1 □ Burial 2 🏋 Cremation 3 □	Bomoval from State	20b. Place of cemeter	Disposition y, crematory	(Name of or other pla	ace)	Date	20c. Locatio	n - City or T	own, State
Pages tment of tant: If its jury or o		4 □ Donation 5 □ Other (Specify	y)	R.A. F				29/09	WEST	CHEST	TER, PA
permit. Departr Importa any inji		21. Signature of Funeral Service Licer			LI	SA SC	ess of Facility OIT FUNER	AL HOME,	P.A.		D 24.070
		23a. Part 1. Enter the disease, or com	plications that caused the	e death. Do n			TS STREET			CE, N	D 21078 Approximate Interval Between
Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. ESOPI	HAGU onseguence c		aA	NCER				Onset and Death
Examiner		Sequentially list conditions	b								
bed sit	xamıner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	onsequence c	of):						
	Exan	that initiated events resulting in death) Last	cDue to (or as a co	onsequence c	of):						
ficate be exphysician sthe burial		(	d								
ertifica ing ph e as th	Medi	IF FEMALE:									
The law requires that the death certificate be eath has been signed by the attending physician bage 2 should be detached for use as the buria	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🔭 0	23c. If yes, outcome of p  1  Live birth 2   4  Pregnant at tin 9  Unknown	Fetal death		pic pregnan er (specify)			1	Date of deli Month	very Day Year
that the	٦ چ	9 ☐ Unknown  Part II. Other significant conditions of	ontributing to death but n	ot resulting in	the underlyi	ing cause gi	iven in Part I.	23e. Did to	bacco use c	ontribute to	the cause of death?
uires than signed	g p							1 🗆 Y	es 2 🗆 No	3 2 Pro	obably 4 🗆 Unknown
aw requir	olete							24a. Was a	an 24	b. Were au	topsy findings available
The law	Completed							autop perfor 1 □ Yes	med? 2 <b>/2</b> No	death?	ompletion of cause of 2 □ No
Physician: The string this certificate and director, page	ge Re	25. Was case referred to medical examiner?	Hospital:				thor:	ath (Check only o			11-00:00
y Phys	<u> </u>	1 Yes 2 100 27. Manner of Death	1 ☐ Inpatient  28a. Date of Injury (Month, Day, Y	2 ER/Ou 28b. T	ime of	28c. Inju	4 LI Nursing F	lome 5 Resid			ity) HOSPICE
ath. r: Afte	atio	1 Pending 2 Accident investigation		(e <i>ar</i> ) Ir	njury M		ork? ⊒Yes 2 □ No				
after de Directo	Certification: 10	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (	- At home, far 'Specify)	rm, street, fa	ctory, office		28f. Location (S City or Tow	treet and Nu n, State)	mber or Ru	ral Route Number,
	Medical C	29a. Certifier (Check only one)	nysician: To the best of r niner: On the basis of ex and manner stated	kamination an	, death occu d/or investig	rred at the ation, in my	time, date and place opinion, death occi	e, and due to the urred at the time,	cause(s) and date and place	I manner as ce, and due	stated. to the cause(s)
To the within To the compl	Me	29b. Signature and title of certifier	707	7		29c. Licer	nse number		29d. Date sig	ned (Month	n, Day, Year)

State

DHMH 17 Rev 1/2001

Registrar

30 Name and address of person who completed cause of death (Item 23a) (Type, Print) SHNIEUE DOBERMAN, MD 555 N. N. TOWSONTOWN BLYD

D64395

JUNE 26-2009

TOWSON, MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 40 AVA Arthur A. Anderson, Jr. JUNE 2009 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ANNE BALTIMORE WASHINGTON MGD CTR LEN BUKMUE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Months 1 XM 2 □ F 95 Maryland June 14,1914 215-10-1602 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County Severna Park MD Anne Arundel 1 ☐ Yes 2 ☑ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21146 USA 76 Riverside Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 ☐Yes 2 🙀 No Specify: White Specify: 3 Widowed 4 Divorced Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Judicial System Judge 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edna Pitcher Crawford Arthur A. Anderson, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 76 Riverside Drive Severna Park, MD 21146 Wife Bonnie Lee Roth Anderson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition June 18. 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, INC. 2009 Baltimore, MD Parranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signature of Funeral Service tricensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation

**Physician** /Medical Examiner

the attending physician and sed for use as the burial-tran

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f shov

Director

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7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Expansioner must be modified at

h and Mental h

27

Department of Important: If It

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Pages 1 and 2 vriment of Health at 27 le

Baltimore,

be filed within 72 hours after death with the Maryland ntal Hygiene.

Examiner Physician/Medical

Completed by Be Certification: To

page 2 should be

certificate has

After this certification

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hours after death uneral Director: filled in by the

To the .
within 24 hour.
To the Funeral D

Physician: The law requires that the death certificate be executed

Record

Division of Vital

6 Could not be

Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 Suicide

4 Homicide

The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainteness of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of cer

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print) CRAIN HWYS. #7, SLEN BURNIE MO 21061

31. Date filed (Month, Day, Year)

9(6 32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar DHMH 17 Rev 1/2001

Medical

			_ FOr	aryland / Dep			lental Hyg	giene	
			State Registrar	<i>Ce</i>	ertificate of l	Death	2. Date of Dea	Reg. No. 2	3. Time of Death
	Physicia	an	Decedent's Name (First, Middle, Last)				Month	28 2009	
	/Medic	al .	ELIZABETH BURKETT  4a. Facility Name (If not institution, give street and number)		4b. City Town or	r Location of Death	06	4c. County of Dea	
	Examin	er	11701 MT. SAVAGE ROAD		CUMBER			ALLEGAN	
· ^	Funeral		5. Social Security Number 6. Sex 7. Ag	e (In yrs. last birthday	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	h 9. Bi	rthplace (State or Foreign ountry)
	Director		217 <b>–</b> 30 <b>–</b> 1829 1□ M 2 <b>X</b> F	74 Yrs.	Months Days	Hours Will.	MAY 8,	1935 M	ARYLAND
	D .		Usual Residence of Decedent  10a, State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
	laryla shor	5	MD ALLEGANY	CUMBER					1 □Yes 2X No
	the N 28a-1	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What C	ountry?
	with		11701 MT. SAVAGE ROAD		21502	?		U.S.A.	
	ms 2	Funeral	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S. 13	. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp	pecify Yes or No-	14. Race - Am Black, Whi	
9	after or ite		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣		1 ☐ Yes 2 X No	Specify:	, thousand otoly	- 44	HITE
000	ural",	d by	3 Widowed 4 N Divorced Year or Dates:	10 2	- 14- 111 0			16b. Kind of Business	
5	"nati	lete	15. Decedent's Education (Specify only highest grade completed)	(Giv	edent's Usual Occup re kind of work done DO NOT use retired	during most of work	king	100, Kind of Busines.	a madati y
21215-0036	filed within 72 hours after death with the Maryland Hygiene. Hygiene. The Western Wither than "natural", or items 23a or 28a-f show ant, the filedical Exertinal must be mattered and and any filedical Exertinal must be mattered.	Completed	Elementary/Secondary (0-12) Unk • College (1-4or 5 Unk •		MEMAKER			HOME	
פַ	il Hyg other /ent,	BeC	17. Father's Name (First, Middle, Last)					Maiden Surname)	
Maryland	uld be Menta nrked stic e	70	ELMER LOCKARD				SMITH		
ar	2 sho and is mi		19a. Informant's Name/Relationship (Type. Print)	- 1				er, City or Town, State	_
≥ oʻ	and Health Im 27		RITA BEAL / DAUGHTER	20b. Place of Disp	49 F INZEL		OSTBURG	20c. Location - City of	
JO.	Pages 1 ment of P ant; If Ite ury or of		20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3 ☐ Removal from State	cemetery, ch	ematory or other plac	ce)		•	
Baltimore,			4 Donation 5 Other (Specify)  21. Signature of Funeral Service/Licensee		ND CREMAT 22. Name and Addre	ess of Facility			AND, MD
Ba	permi Depar Impor any ir once.	ė į	Mond A Trock	11108	LIDCHLIBCE	I FINERAL	HOME, I	P.A. ERLAND, MD	21502
			23a. Part 1. Enter the disease, or complications that cause		nter the mode of dyi	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between
3.	Physician	8 1	shock, or heart failure. List only one cause on each li Immediate Cause (Final disease or condition	Le My	Ocardi	al In	hert	on	Onset and Death
	/Medical		resulting in death)	a consequence of):			4.5		
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	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	a consequence on.					
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68	rtificai ng phy as th	ledi							
P.O. Box	ires that the death certific signed by the attending I i be detached for use as	Physician/Me	IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant 1 ☐ Live birth		B 🗆 Ectopic pregnanc	су		23d. Date of o	lelivery Day Year
С Ш	e dea the at ned fo	sici	in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	at time of death 5	5 ☐ Other (specify) _				<b></b> ,
<u>o.</u>	hat th ad by Jetach		Part II. Other significant conditions contributing to death b	out not resulting in the	underlying cause giv	ven in Part I.	23e. Did t	tobacco use contribute	to the cause of death?
ds,	signe d be	d by	Coronan Arte	~ D/5	0650		10	Yes 2⊡No 3🗖	Probably 4 🗌 Unknown
S	v requ	ete	Lane leusian	7			24a. Was	an 24b. Were	autopsy findings available
Be	he lav e has	Completed	- CF/FE-FEUSTON				auto perfo		o completion of cause of ? es 2 □ No
ta	an; T tificat tor, pa	Be C	25. Was case referred to medical			26. Place of Dea			55 2 LINO
<u> </u>	nysici iis cer direc		examiner? 1 ☐ Yes 2 🛣 No Hospital: 1 ☐ Inpati	ent 2 ER/Outpat	ient 3 DOA Oti	her: 4  Nursing H	lome 5 🛣 Resi	idence 6 □Other (S	pecify)
Division of Vital Records,	ding Physician; The law requir h. After this certificate has been s funeral director, page 2 should	L:uo	27. Manner of Death 28a. Date of Inj. 1 Natural 5 ☐ Pending (Month, Date of Inj. (Month, Dat	ury 28b. Time ay, Year) Injury	y Wo		28d. Describe	how injury occurred	
sio	tendi eath. or: A the fu	cati	2 Accident investigation			]Yes 2□No	204 Leasting	Character and Alicenters on	Rumi Pouto Number
Ž	or At after d Direct in by	Certification: To		jury - At home, farm, s tc. <i>(Specify)</i>	street, factory, office		City or To	Street and Number or wn, State)	nurar noute Nurriber,
ш	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 X Certifying Physician: To the best	of my knowledge, de	eath occurred at the t	time, date and plac	e, and due to the	e cause(s) and manner	as stated.
	e Hos 1 24 h e Fur itetely	Medical	(Check only 2 Medical Examiner: On the basis one) and manners	of examination and/or	r investigation, in my	opinion, death occi	urred at the time	, date and place, and c	lue to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier		29c. Licen	se number		29d. Date signed (Mo	onth, Day, Year)
	6		J Klu	6/1 Pm	1	557	550	0/27	109
			30. Name and address of person who completed cause of	11	1 . 0	94745	540	Mappell	mD
	MIS		31. Date filed (Month, Day, Year) 32. Regist	rar's Signature	Many	1111	C 13		
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2009 15:40 19, JUNE MARY CATHERINE BIRMINGHAM 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) ALLEGANY CUMBERLAND WMHS MEMORIAL CAMPUS f Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Days Hours 1 □ M 2 🗓 F 16, 1924 MARYLAND 85 JAN. 218-16-3876 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 1 ☐Yes 2 XNo ALLEGANY CUMBERLAND MD 10g. Citizen of What Country? 10e Street and Number U.S.A. 21502 730 FURNACE STREET 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WW I I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: WHITE 3 □Widowed 4 □ Divorced 16a Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) HOSPITAL NURSE'S AIDE 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BLANCHE NORMAN HARLEY STEVEN LOGUE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BROADWAY CIRCLE, CUMBERLAND, MD 21502 SHARON MARVIN / DAUGHTER Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CUMBERLAND CREMATORY 06/22/2009 CUMBERLAND, MD 4 Donation 5 Dother (Specify) 2. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, of Funeral Service 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ears disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): E FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Marti 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No F Decidence 6 DOther (Specify)

**Physician** /Medical Examiner Examiner law requires that the death certificate be executed

Department of Health an important: If Item 27 is any injury or other trauonce.

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

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7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the IW dign Examinating to notified at

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death v

72 hours after

I be filed within 7 intal Hygiene. n and Mental Hygiene.

Pages 1 and 2 should

Baltimore, Maryland 21215-0036

Box 68760.

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Division of Vital Records,

Physician:

anding physician and use as the burial-tran attending for s been signed by the should be detached certificate has page 2 s

Physician/Medical ð Completed funeral director, Be this Certification: To After t spital or Attendi nours after death. neral Director: A / filled in by the fu death. Hospital

To the Hospital within 24 hours a To the Funeral C completely filled Medical JACORT

110	i jajinpanent 2 L	Li i Odipationi O II i	JOH TE Harsing I	Totale DE Tresidence of Element Telegram,
h 5 ☐ Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury occurred
6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, factory)	28f. Location (Street and Number or Rural Route Numb City or Town, State)	
1 Certifying Physi 2 Medical Examine	cian: To the best of my kno er: On the basis of examina	owledge, death occurre ation and/or investigati	ed at the time, date and place on, in my opinion, death occu	e, and due to the cause(s) and manner as stated.  urred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

27. Manner of Death

Natural

3 Suicide 4 Homicide

29a. Certifier

2 Accident

(Check only one)

30. Name and address of

29c. License number 046346 29d. Date signed (Month, Day, Year)

venue, Cumber and,

State Registra

DHMH 17 Rev 1/2001

31. Date filed (Month

and manner stated.

person, who completed cause of death (Item 23a) (Type, Print)

parks

09-05086 Timothy Brewer

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Same	U	U	2	Contr	Car	1	0	-

		I- For State Registrar		Ce	ertificate of	Death			Reg. No.	40	00 2210
Physicia	ın/	1. Decedent's Name (First, Middle, Last)  TIMOTHY PAUL BREWER, SR.							of Death th Day	Year	3. Time of Death 2155 hrs
Medical Examii						b. City, Town,	or Location of		27, 2009	County of Dea	
		4a. Facility Name (if not institution University Hospital	on, give street and n	umber)		Baltimore					
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	. last birthday)	If Under 1 Y	ear If Under	24Hrs. 8. Da Min.	te of Birth(MM/E	DD/YYYY) 9. B Fore	irthplace (State or ign
Director		215-86-4732	1 <b>X</b> M 2 F	46	Yrs		ays	SE	PT. 15,	1962 MA	RYLAND
,		Usual Residence of Decedent 10a. State 10b. County		I 100 Cit	ty, Town or Locat	on					10d. Inside City Limits
ow any											1 Yes 2 X No
daryland 28a-f show 1 at once.	흕	MARYLAND QUE  10e. Street and Number	EN ANNE'S	<u> </u>	UEEN AND	10f. Zip Code	e		10g. Citiz	en of What Co	untry?
ē 2	Director	624 DAMSONT	OUN DOAD			2165				TED ST	
with the s 23a c noti	= 4	11. Marital Status		ecedent Ever in	U.S. 13. Wa			in? ( Specify Ye			erican Indian, Black,
death w	Fune	1 Never Married 2 X	Married Armed I	Forces?	If Y	es, specify Cul	ban, Mexican,	Puerto Rican,	etc.)	White, etc.	
after o	by F	3 Widowed 4 Di	vorced If Yes, Give Ye		1	Yes 2 🗶	No specify:				HITE
5-0036 led within 72 hours after tygiene. other than "natural", the Medical Examiner.		15. Decedent's Education (Spe				it's Usual Occur ost of working		ind of work dor use retired)	ne 16b. K	and of Busines	s/Industry
36 in 72 han "	Completed	Elementary/Secondary (0-12)	College	(1-4 or 5+)	SIIP	ERVISOR			1	PRINTIN	G
d with	틝	17. Father's Name (First, Middle	e, Last)					s Name (First, I	Middle, Maiden		
21215-0036 Buld be filed within 7 Mental Hygiene. marked other than	Be	STANLEY E. B	REWER				FAY	E TOLLE	ΞY		
21 ould b d Men s mar		19a. Informant's Name/Relation	ship (Type, Print)			,			oute Number, Ci		
MD nd 2 sho alth and m 27 is		MARY SUE BRE	WER/WIFE						JEEN ANN	NE, MD	21657
nore, MD 2121 gges I and 2 should be fi nt of Health and Mental I tt: If item 27 is marked other traumatic event,		20a. Method of Disposition  1 Burial 2 X Crematic	on 3 Removal	from State	Place of Dispos	KE plaCREM	ATION	JUNE 2	29	Location - City	or rown, State
Page ment c		4 Donation 5 Other S			CEN			2009			ILLE, MD
Baltimore, MD 21215-C permit. Pages I and 2 should be filed to Department of Health and Mental Hygi Important: If item 27 is marked oth injury or other traumatic event, the		21. Signature of Funeral Service	Licensee	e	FE	LLOWS,	HELFEN	BEIN &	NEWNAM	FUNERA	L HOME, P.A.
Physician		23a. Part I. Enter the disease, o	or complications that	caused the dea							LE, MD 21617 Approximate Interval
/Medical		failure. List only one cause	e on each line.								Between Onset and Death
caminer		Immediate Cause (Final diseas or condition resulting in death)		a consequence	e of):						1
		Sequentially list conditions,	b								
	ine	if any, leading to immediate cause. Enter Underlying Cause		a consequence	e of):						
T ti	Examiner	events resulting in death) Last	Due to (or as	a consequence	e of):						
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o, e be e: ysiciar burial	n/Medical	UNPENDED	AMENDED						224	d, Date of deliv	Yon
<b>∞</b> = 20 s	٤	IF FEMALE: 23b. Was decedent pregnant in		s, outcome of properties		etal death	3 Ectopic	pregnancy	230	Month	Day Year
Box 687 he death certific the attending pred for use as the	icia	past 12 months?		gnant at time of	1 41	ther (Specify)					
Bc he dea the a	Physicia	1 Yes 2 No 9 U	9_011	nown	ttime in the	underlying cou	ee siyon in Bo	et 1 2º	3e Did tobacco	use contribute	to the cause of death?
P.O. s that th gned by e detach		Part II. Other significant cond	itions contributing	to death but no	t resulting in the	underlying cau	se given in Fa				Probably 4 Unknown
4S, guires	Completed by							124	4a. Was an	24b. Were	autopsy findings available
COFC law re has be 2 sho	ed							<del></del>	autopsy performed?	prior t death	to completion of cause of ?
Ref	S						(5-1)		Yes 2 N	lo 1 🗸	Yes 2 No
ital siciam s certi	Be	25. Was case referred to medic examiner?		Inpatient 2	ER/Outpatien		Other	(Check only on Nursing Hom		ence 6 Ot	her:
Division of Vital Records, P.C rial or Attending Physician: The law requires that its after death.  al Director: After this certificate has been signed led in by the funeral director, page 2 should be deat	<u>٩</u>	1 ✓ Yes 2 No 27. Manner of Death	28a. Da	te of Injury	28b. Time of		Injury at Work	? 28d. E	Describe how inj	ury occurred	
OD C	ţi		luling	th Day Year) , 2009	2039 hrs	1	Yes 2 ✔	No Drive	r auto fixed	object collis	sion
/iSi r Atti ter de irecte	ţica		estigation 28e. Pla	ace of Injury - A	t home, farm, stre	et, factory, offi	ce building, et				Rural Route Number, City
Division Hospital or Attend 24 hours after death Funeral Director:	Certification			y) Major Ro	oad / Highway		<u>.</u>	Route	481 and Gree	enville Road,	Centreville, MD
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use a		29a. Certifier (Check only one) Certifying I Certifying I	Physician: To the basi	est of my knowl s of examination	edge, death occu n and/or investiga	rred at the time	e, date and pla nion, death oc	ace, and due to curred at the ti	the cause(s) ar	nd manner as s ace, and due to	tated. the cause(s)
To t To t	Medical	29b. Signature and title of certif	and manner	stated.			ense number				Month, Day, Year)
		Mouse 1	bill.	0		0	.C.M.E.		Jun	ne 28, 2009	
Y		30. Name and address of person	on who completed ca	use of death (It	em 23a)	L			1		
MS		Margarita Korell MD.				enn Street	, Baltimore	e, MD 2120	1		
	ate	31. Date filed (Month, Day, Year		Registrar's Sign	nature				·		
Regist	rar	JUN 2	9 2009 🔏	enema	A. A.	Kal					

		-	For State of Ma  State of Ma  Registrar	aryland / Depa <i>Ce</i>	artment of F rtificate of L			<sub>eg. No.</sub> 2 ()	109 221	87
	Physicia	an	Decedent's Name (First, Middle, Last)     BRIDGETTE BARTON				2. Date of Deat Month	Day	3. Time of De 2009 4:10	115.5
~ .	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	June		y of Death	AM
			Genesis HealthCare - T  5. Social Security Number 6. Sex 7. Age	he Pines (In yrs. last birthday)	E If Under 1 Year	aston If Under 24 Hrs.	8 Date of Birth		albot	Foreign
ı	Funeral Director		214-54-7531 1 □ M 2 X F	45 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day) JUNE 24	Year) 1963	9. Birthplace (State or F Country) MARYLAND	o. 0.g, r
	ww		Usual Residence of Decedent  10a, State 10b, County	10c, City, Town or Lo	ocation				10d. Inside City	Limits
	Maryia -f sho	tor	MARYLAND CAROLINE	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		NTON			1 <b>X</b> Yes 2	□No
	or 28a	Director	10e. Street and Number		10f. Zip Code	111011	1	0g. Citizen of	What Country?	
	s 23a		309 FLEETWOOD ROAD		21629				ED STATES	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Endire characteristic of the any injury or other traumatic event, the Medical Endire characteristic of the once.	by Funeral	11. Marital Status  1 □ Never Married  2 ▼ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent E Armed Forces?  1 □ Yes 2 ▼ N If Yes, Give Year or Dates:	lo l	Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 No	Specify:	Rican, etc.)		ace - American Indian, ack, White, etc.	
5-0	72 ho "natur	etec	15. Decedent's Education (Specify only highest grade completed)	i (Give	edent's Usual Occup kind of work done	during most of work		16b. Kind of E	Business/Industry	
121	within iene. than	Completed	Elementary/Secondary (0-12) College (1-4or 5-		DO NOT use retired  KNOWN	"		UNKN	IOWN	
<b>p</b> 2	e filed al Hyg other	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, I	Maiden Surna	me)	
ylaı	ould b	2	JAMES BARTON				STALLING			
Maryland	id 2 sh Ith and 27 Is m traum		19a. Informant's Name/Relationship (Type. Print)  ASHLY W. ASBURY/ SON		ing Address (Street : FLEETWOOD					
re,	ss 1 an of Hea item ?		20a. Method of Disposition	20b. Place of Dispo	osition (Name of		Date		- City or Town, State	
Baltimore,	Page tment tant: If		1 ☐ Burial 2 <b>X</b> Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	CE	REOCKEMAT NTER	200	19		SVILLE, MD	
Ball	permit Depart Import any in		21. Signature of Funeral Service Licensee	1	106 SHAMR	OCK ROAD.	CHESTE	R. MD 2	NERAL HOME, P 21619	P.A.
	Physician		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause the each lin Immediate Cause (Final disease or condition					rest,	Approximate Interval Betwee Onset and De	ath
	/Medical Examiner		resulting in death)  Due.t. or as a	a consequence of):	undefor	inner V	ivne			
	ש ±	iner		a consequence of):	arracje	)	70.7			
	icate be executed physician and s the burial-transit	Examiner	that initiated events c.	a consequence of):						- 1
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99	entifica ing ph	Medi	IF FEMALE:							
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	23b Was decedent pregnant 23c. If yes, outcome	2 Fetal death 3	☐ Ectopic pregnanc ☐ Other <i>(specify)</i> _	у			ate of delivery Month Day Ye	ar
ds, P.	w requires that the d been signed by the should be detached	by	Part II. Other significant conditions contributing to death but I new files and the significant conditions contributing to death but I new files and the significant conditions contributing to death but I new files and the significant conditions contributing to death but I new files and the significant conditions contributing to death but I new files and the significant conditions contributing to death but I new files and the significant conditions contributing to death but I new files and the significant conditions contributing to death but I new files and the significant conditions contributing to death but I new files and the significant conditions contributing to death but I new files and the significant conditions contributing to death but I new files and the significant conditions contributing to death but I new files and the significant conditions contributing the significant conditions contributing the significant conditions	at not resulting in the u	underlying cause giv	en in Part I.	23e. Did to		ntribute to the cause of dea	
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Be	The law ate has bage 2 a	omo					autop: perfor 1 🗆 Yes		prior to completion of cau death? 1 □ Yes 2 □ No	use of
/ita	clan: sertifica setor, p	Be C	25. Was case referred to medical examiner?		011	26. Place of Deal	th (Check only or	ne)		
of	ding Physician: The In. After this certificate hatfuneral director, page	<u>و</u>	1  Yes 2 No Hospital: 1  Inpatie  27. Manner of Death 28a. Date of Injur	ent 2 ER/Outpatie		er: 4 Nursing H	ome 5 Resid			
ion	ath. r: Afte	atior	1 Natural 5 ☐ Pending (Month, Day 2 ☐ Accident investigation	y, Year) Injury	Wor	ќ? Yes 2 ∐No				
Division of Vital Record	il or Atte after des I Directo d in by th	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Inju building, etc	ury - At home, farm, st c. (Specify)	treet, factory, office		28f. Location (S City or Tow	treet and Nun n, State)	nber or Rural Route Numbe	er,
	To the Hospital or Attending Physician: within 42 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, p.	edical C	29a. Certifier (Check only one)  Certifying Physician: To the best of and manner sta	f examination and/or i	ath occurred at the ti investigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and i	manner as stated. e, and due to the cause(s)	
	To th To th comp	Me	29b. Signature and title of certifier		29c. Licens	e number		29d. Date sign	ned (Month, Day, Year)	
	)		30 Name and address of area	eath /Itam 00-1 /T	Drint)	ハレフトフタ		E	016907	
			30. Name and address of person who completed cause of de MICHALL ROWLLY MD  31. Date filed (Month, Day, Year)  32. Registre	eath (Item 23a) (Type C/O	POTCHMAN	's LANC	LA	STON, [	no 2160	16
	Sta Registr		JIN 2.6 2009		hores					

Bridgette Barton

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2009 June 25, **Physician** William E. Bromley, Jr. 12:19 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Spring 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Day, Yes
July 14, Birthplace (State or Foreign
Country) **Funeral** Year) 1925 Washington, DC 1**⊠**M 2□F Months Days Hours 577-22-9897 83 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a. State 10h County 28a-f shov must be notified at 1 ☐ Yes 2 TNo Director Maryland Montgomery Bethesda 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò 20814 IISA 10518 Weymouth Street 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or items, event, the Medical Examiner 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: <u>م</u> 3 X Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygiene important: If Item 27 is marked other than any injury or other traumatic event, Item Monce. Salesman Printing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William E. Bromley Henrietta Carress ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Penelope A. Garland/Daughter 3590 Daisy Road, Woodbine, MD 21797 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Ĩ8, Aug. 2009 1 ■ Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National 4 ☐ Donation 5 ☐ Other (Specify) Arlington, Virginia 21. Signature of Funeral Service Licensee Francis Address of Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Pulmonary Embolus disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed A hours after death.

A hours after doesn. After this certificate has been signed by the attending physician and stely filled in by the funnerial director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the ceuse of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖰 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy 1 □Yes 2K No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after the Funeral Discompletely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title or certifier 29d. Date signed (Month, Day, Year) 29c. License number June 25, 2009 D62571 10-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, MD 20910 Sarah Bromeland, MD 31. Date filed (Month, Day, Year) 3 Registrar's Signat State JUN 26 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician Denise Michelle Brining 5:16A M lune 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Min 1□M 2 1 F Months Days Hours 43 Director Maryland Oct. 7, 1965 <u>220-82-4810</u> Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 Yes 2 □ No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 USA 1203 Potomac Avenue Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American îndian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 🔀 If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 David Weaver Carol Ecton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald Brining 1203 Potomac Avenue Hagerstown, Maryland 21740 (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 D Burial 2 Cremation 3 Removal from State 5 ☐ Other (Specify 4 Donation Smithsburg, Crematory 6-30-09 Smithsburg, Maryland 22. Name and Address of Facility
Osborne Funeral Home P.A. 425 S. Conococheague St. ature of F Williamsport, Maryland 21795 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer bdominal **Physician** /Medical Due to (or as a consequence of): Examiner Absuss in Saguration list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and Due to (or as a consequence of) of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been si page 2 should t 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 3 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ After this nours after death.

neral Director: After this filled in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1.P Natural 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital or 24 hours 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0060396

10H-0

31. Date filed (Month, Day, Year)

32. Registrar's Signature

H(C)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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ORIGINAL

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Month June 25, 7:10 A M Felicia E. G. Bustamante 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery 20800 Brooke Knolls Road Gaithersburg Birthplace (State or Foreign Country)

Cuba 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Feb 21, 84 Months Days Hours Min 1 ☐ M 2 🖫 F 266-70-4308 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ☐Yes 2 No Montgomery Gaithersburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7921 Goodhurst Drive 20882 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Cuban 1X Yes 2 □ No Specify: White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary International Org. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Francisco San Miguel Trucio Juana Bienvenida de la Incera Hernandez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Aida G. de Bustamante/daughter 20800 Brooke Knolls Rd. Gaithersburg, MD 20882 20a. Method of Disposition
1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Final Journey Crematory 06/26/09 | Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Senvice License Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) years Severe Dementia Due to (or as a consequence of): Parkinson's Disease 5 years Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 9 Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 🖪 No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) daughter's Hospital: Other: 4 Nursing Home 5 Residence 6 NOther (Specify 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical **Examiner** 

Department of Health a Important: If Item 27 is any injury or other trains once.

Pages 1

Physician

**Examiner** 

**Funeral** 

**Director** 

show

Director

Funeral

2

Completed

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d 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiene. ?? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exam in more used to notified at

Maryland 21215-0036

Baltimore,

/Medical

Examiner burial-trar attending physician for use as the buria Physician/Medical signed by the a þ Completed Be Certification:

the death certificate be executed P.O. Box 68760 Division of Vital Records, Physician: Hospital or Attending P
 24 hours after death.
 Funeral Director: After t To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu

1x por

State Registrar

DHMH 17 Rev 1/2001

5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D35965 June 25, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David B. Harding, 18]11 Prince Philip Dr. Suite 300 Olney, MD 20832 M.D.

31. Date filed (Month. D

Medical

1 X Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

			For State Registrar		State of Ma	arylano		rtificate of i		vientai my	/gieri Reg. N		00101
	Dhamini		1. Decedent's Name (	First, Middle, La	st)					2. Date of D Month	eath	2005	3. Time of Death
	Physicia /Medic				e B. Buckl	ey				June	25		7:10 A M
	Examin	er	4a. Facility Name (If n						r Location of Death 11stown	1	4	c. County of Deat Balti	
Service A	Funeral		Northwest  5. Social Security Nun			e (In yrs. las	st birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of B	irth .		
	Director		219 01 25 Usual Residence of D	47	I□M 2\$20F	90	Yrs.	Months Days	Hours Min.	01/12	/19	19 M	thplace (State or Foreign buntry)
yland	at			0b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
e Mar	a-f sk tiffied	ctor	MD	Balt	imore	Wiı	ndsor	Mill					1 □ Yes 2 🕍 o
ith the	or 28 3e no	Dire	10e. Street and Numb					10f. Zip Code				Citizen of What Co	
ath w	s 23a nust t	eral	8719 Wrig	hts Mil		Francia II C	40.1	21244		if V 1		nited St	
is intentional to the indicate within 72 hours after death with the Maryland	Health and Mental Hygiene. Item 27 Is marked other than "natural" or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status  1 ☐ Never Married  3 ☐ Widowed 4		12. Was Decedent Armed Forces?  1  Yes 2  If Yes, Give Year or Dates:			Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ispanic Origin? (S an, Mexican, Puerl Specify:	pecity Yes of N to Rican, etc.)	0-	Black, Whit	
72 ho	natur Jical I	Completed	1 (Specify	5. Decedent's E	ducation ade completed)		16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wor	rking	16b.	Kind of Business	/Industry
ithin it	han " e Mec	mpl	Elementary/Second		College (1-4or 5	5+)			d)	5	T2).	- J C	
y pelli	Hygie thert int, th		17. Father's Name (Fi	irst. Middle. Last	2		S	ecretary	18. Mother's Nan	ne (First, Middl			overnment
d be	ental ked o Ic eve	To Be	Frederick						Mary E.	Linnba	um	,	
shou	and Mental Hygiene. Is marked other than aumatic event, the Me	-	19a. Informant's Nam	ne/Relationship (	Type. Print)			ng Address (Street					•
and 2	ealth a		Susan Gro	sko/Fri	end			Peddicoa		Woodsto	ck,	MD 2116	3
Pages 1	if item		20a. Method of Dispos 1 X Burial 2 □		Removal from State	20b. Pla	ce of Dispo netery, crei	sition (Name of matory or other plac		Date		Location - City or	
- Pag	tment tant: jury o		4 ☐ Donation 5	☐ Other (Speci	fy)	St.	J.	onsus Cen		/2009		odstock,	
permit.	Department of Health a Important: If item 27 is any injury or other tra		21. Signature of Fund	eral Service Lice	with the	M010	$\begin{array}{ c c c c c c c c c c c c c c c c c c c$	2. Name and Addre $112$ Old $$ C	<sup>ss of Facilit</sup> Har Columbia	ry H. W Pike El	litz lic	ke's Fam ott Citv	ily FH Inc. , MD 21043
8	•		23a. Part1. Enter the shock, or heart	disease, or com failure. List only	plications that caused one cause on each lin	the death.							Approximate Interval Between
	ysician		Immediate Cause (Fi disease or condition					Disease					Onset and Death
4	Medical aminer		resulting in death)		Due to (or as	a conseque	nce of):						
\$		Je.	Sequentially list cond	litions,	b. Atner	oscle:							
uted	ansit	Examiner	Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Disease or in that initiated events	ring siury	_		,						
exec	an and rial-tra	Еха	resulting in death) La	st	Due to (or as	a conseque	nce of):						
ificate be executed	ng physician and as the burial-transit	edical			d								
	ing ph e as t		IF FEMALE:										
To the Hospital or Attending Physician: The law requires that the death cer	been signed by the attending should be detached for use a	Physician/M	23b. Was decedent p in the past 12 m 1 ☐ Yes 2X 9 ☐ Unknown	onths?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal d	leath 3	∃Ectopic pregnanc ∃Other <i>(specify)</i> _	у			23d. Date of de Month	livery Day Year
s that	ned b	by Pł	Part II. Other signific	ant conditions	contributing to death b	ut not resulti	ing in the u	nderlying cause giv	en in Part I.	23e. Did	tobacc	o use contribute to	o the cause of death?
aduire	en sig	ed t	Cardiamy	opathy,	Atrial Fi	brill	ation			1	] Yes	2 <b>⊠</b> No 3□P	robably 4 □Unknown
The law r	rr death. <b>rector:</b> After this certificate has be by the funeral director, page 2 sh	Completed	Chronic	Obstruc	tive Pulmo	nary 1	Disea	se		24a. Wa aut per 1∐ Yes	opsy formed?	prior to death?	utopsy findings available completion of cause of s 2 □ No
v I v	sertific ector,	Be	25. Was case referre examiner?		Hospital:			Loth	26. Place of Dea	ath (Check only	one)		
Phys	r this ral dir	.T	1 ☐ Yes 2 No.	0	28a. Date of Inju	ent 2 ⊟El	R/Outpatier 28b. Time o		4 □ Nursing F	dome 5 ☐ Res 28d. Describe		6 □Other (Spe	ecify)
gulb	h. : After	tion	1X Natural 2 ☐ Accident	5 ☐ Pending investigatio	(Month, Da	y Year)	Injury	Wor	k? Yes 2∐No	Zod. Describe	, now in	jury occurred	
or Atter	after death.  Director: After in by the funer	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	e 28e. Place of injubuilding, et	ury - At hom c. (Specify)	ne, farm, str	eet, factory, office		28f. Location City or T	(Street own, Sta	and Number or R ate)	ural Route Number,
e Hospital	wthin 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Medical Co			hysician: To the best miner: On the basis o and manner sta	f examination							
To th	To th comp	Me	29b. Signature and tit	e of certifier				29c. Licens	e number		29d. [	Date signed (Mon	th, Day, Year)
•			) Of A	ang	anap	Li	MX	D54	4288			June 25,	2009
10	EG				completed cause of d			Print) Court Ro	oad Randa	allstown	n, M	D 21133	
	Sta Registr	_	31. Date filed (Month,	Day, Year)	2009 32. Registr	ar's Signatu	A. X	barke					

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. U 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Melba E. Band 2000 4:30 pM 18% June 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Annapolis Anne Arundel Medical Center 8. Date of Birth (Month, Day, Ye Jan. 13, Birthplace (State or Foreign Country) Republic of If Under 1 Year | If Under 24 Hrs. 5. Social Security Number <sup>Year</sup> 1956 6 Sex 7. Age (In vrs. last birthday) Months Days Hours 1 □ M 2 🕱 F 571-41-6999 the Philippines Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State MD Anne Arundel Annapolis 1 ☐ Yes 2 ☐ No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1216 Plateau Place 21409 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11 Marital Status 1 ∐Yes 2 **X**No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: Asian 3 ☐ Widowed 4 ☐ Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home Δ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marcela H. Balintong Hilario B. Amaro 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Annapolis, MD 21409 1216 Plateau Place Jean A. Band/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date June 19, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Baltimore, MD 4 Donation 5 Other (Specify) 2009 21. Signature of Funeral Service License 22. Name and Address of Facility Barranco & Sons, P.A. 495 Gov. Ritchie Hwy. Severna Park Funeral H Severna Park, MD 21146 Severna Park, 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) □Yes 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 → Mo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops performed 2 No 1 ☐Yes 2 Mo

26. Place of Death (Check only one)

Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

**Physician** 

**Examiner** 

**Funeral** 

Director

If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the "Action Examiner must be notified at

Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mental and injury or other traumatic event, the Mental and injury or other traumatic event, the Mental and injury or other traumatic event, the Mental and injury or other traumatic event, the Mental and injury or other traumatic event, the Mental and injury or other traumatic event, the Mental and injury or other traumatic event, the Mental and injury or other traumatic event, the Mental and Injury or other traumatic event, the Mental and Injury or other traumatic event, the Mental and Injury or other traumatic event, the Mental and Injury or other traumatic event, the Mental and Injury or other traumatic event, the Mental and Injury or other traumatic event, the Mental and Injury or other traumatic event, the Mental and Injury or other traumatic event, the Mental and Injury or other traumatic event, the Mental and Injury or other traumatic event, the Mental and Injury or other traumatic event, the Mental and Injury or other traumatic event, the Mental and Injury or other traumatic event, the Mental and Injury or other traumatic event, the Mental and Injury or other traumatic event, the Mental and Injury or other traumatic event, the Mental and Injury or other traumatic event, the Mental and Injury or other traumatic event, the Mental and Injury or other event, the Mental and Injury or other event, the Mental and Injury or other event, the Mental and Injury or other event, the Mental and Injury or other event, the Mental and Injury or other event, the Mental and Injury or other event, the Mental and Injury or other event, the Mental and Injury or other event, the Mental and Injury or other event, the Mental and Injury or other event, the Mental and Injury or other event, the Mental and Injury or other event, the Mental and Injury or other event, the Mental and Injury or other event, the Mental and Injury or other event, the Mental and Injury or other event, the Mental and Injury or other

filed within 72 hours after death

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

/Medical

Director

Funeral

à

Completed

Be

Examiner burial-transi and attending physician for use as the buria Physician/Medical signed by the a d be detached f δ icate has been sig , page 2 should b Completed this certificate Be Certification: To

law requires that the death certificate be executed funeral director, al or Attending P after death. I Director: After d in by the funera After filled in by

To the Hospital c within 24 hours af To the Funeral D Medical Registrar

31. Date filed (Month, Day,

25. Was case referred to medical examiner?

1 Tes 2 Ho

27. Manner of Death

1 Natural

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of certifier

75

3 Suicide

29a. Certifier

Hospital:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 Pending investigation

6 Could not be determined

1 Inpatient

Date of Injury (Month, Day, Year)

900 mo 32. Registrar's Signature

2 ER/Outpatient 3 DOA

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 □ Yes

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

	1 - For State Registrar	State of Marylar		rtificate of			g. No 2 () ()	9 22193
ı	1. Decedent's Name (First, Middle, Last)	T (	3R4a	WT		2. Date of Death Month		3. Time of Death 09 5:25 a M
ı	4a. Facility Name (If not institution, give str			,	Location of Death	June	4c. County of E	
i	Anne Arundel Medic	al Center			napolis			e Arundel
	407-10-0372	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, NOV • 7,	Vear	Birthplace (State or Foreign Country) Kentucky
	Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	MD Anne Aru	ndel	Arnold					1 □Yes 2 🙀 No
	10e. Street and Number 428 Century Vista	Drive		10f. Zip Code	21012	10	g. Citizen of Wha	t Country? USA
	11. Marital Status	2. Was Decedent Ever in U Armed Forces?	I.S. 13.	Was Decedent of H	ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or No- o Rican, etc.)		American Indian, Vhite, etc.
	1 ☐ Never Married 2 🙀 Married 3 ☐ Widowed 4 ☐ Divorced	1 XXYes 2 □ No If Yes, Give WW Year or Dates: WW		1 □Yes 2 🙀 No	Specify:		opcony.	White
	15. Decedent's Educa (Specify only highest grade of	completed)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	ation during most of worl f)	king	l6b. Kind of Busin	ess/Industry
	Elementary/Secondary (0-12)	College (1-4or 5+)	1	ectronic		1	Littor	n Industries
	17. Father's Name (First, Middle, Last)					ne (First, Middle, N	faiden Surname)	
	Amos Greene Bryant					Duke		
	19a. Informant's Name/Relationship (Type Antoinette D. Brya	nt/Wife	428	ng Address (Street Century	Vista Dr	ive A	rnold, M	D 21012
	20a. Method of Disposition 1 ☐ Burial 2 <b>Ø</b> Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)			osition (Name of matory or other place rematory		<sup>Pate</sup> 22 <b>,</b> 009	Baltimo	
	21. Signature of Funeral Service Licensee	2/1.	I	2. Name and Addre	& Sons, I	P.A. Sev	erna Par	k Funeral Hom
-	23a. Part 1. Enter the disease, or complica	ations that caused the dea		495 GOV . ter the mode of dyir				Approximate Interval Between
	shock, or heart failure. List only one Immediate Cause (Final disease or condition	cause on each line.	12 16	ret £	alun			Onset and Death
	resulting in death)	Due to (or as a consec	quence of):	961	C(LIONE			24.5
	Sequentially list conditions. b.	Preu	nous					Day
	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a conse	quence of):					
	that initiated events c. resulting in death) Last	Due to (or as a consec	quence of):	-				
	<b>€</b> d.			_				
	IC CEMALE.							
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet	al death 3	☐ Ectopic pregnanc	у		23d. Date of	
	1 Yes 2 No	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5[	Other (specify) _				
	Part II. Other significant conditions contr	ributing to death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribu	ute to the cause of death?
1						1 □ Ye	s 2 No 3	robably 4 Unknown
						24a. Was a	24b. We	re autopsy findings available or to completion of cause of
			-			perforr	ned? dea	ath? ]Yes 2X≦No
	25. Was case referred to medical examiner?				_	ath (Check only on	e)	
	1 Yes 2 PAo	spital: 1 Inpatient 2	_		4 Li Nursing F	lome 5 Reside		(Specify)
	27. Manner of Death  1 Hatural 5 Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	Wor	yet k? Yes 2∐No	28d. Describe no	w injury occurred	
	3 Suicide 6 Could not be	28e. Place of Injury - At I building, etc. (Spec	nome, farm, str		100 10.00	28f. Location (St	reet and Number	or Rural Route Number,
	4 Homicide	building, etc. (Spec	ity)			City or Town	n, State)	
		cian: To the best of my kner: On the basis of examinand manner stated.						
	29b. Signature and title of certifier	M		29c. Licens	number N35 4	94 2	9d. Date signed ()	Month, Day, Year) 19, 2009
	30. Name and address of person who com	npleted cause of death (Ite	em 23a) (Type,	Print) Anne	ARine	le ma	fical	corten
	31. Date filed (Month, Day, Year)	32. Registrar's Sign				· · · · · · · · · · · · · · · · · · ·		
	JUN 23 200	19 Burn	A. 1	are				
-		1	1					

DHMH 17 Rev 1/2001

State

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 6/22/2009 Leonard William Bender 0747 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Yea 5/2/1927 Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1**X**XM 2□ F 220-16-5399 82 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant of Health and Marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mentlal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Modical Examination in the modified at once. 1 ☐ Yes 🛣 No Funeral Director MD Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 218 Old Mill Bottom South 21409 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status 1 Yes 2 <sup>2</sup>□No WWII 1 Never Married & Married Saltimore, Maryland 21215-0036 δ 1 ☐ Yes 2 ☐ No Specify White 3 Widowed 4 Divorced Year or Dates Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Planning & Estimator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leonard Lewis Bender ပ Philomena Juraneck 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 218 Old Mill Bottom South Annapolis, Md 21409 Shirley Bender Wife
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date MXBurial 2 ☐ Cremation 3 ☐ Removal from State St. Margarets Cemetery 6/26/2009 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee 12 Ridgely Ave. Annapolis, MD 21401 aw 23a. Part 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 20 years resulting in death) /Medical Due to (or as a confequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Puneral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) I ☐ Yes 2 ☐ No 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □ Yes 2 🗆 No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar

Medical

29a, Certifier

(Check only one)

30. Name and address

29b. Signature and title of certif

To the Within 2

ELD

of death (Item 23a) (Type, Print)

and manner stated

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

M.D

			State of Maryland / D  State of Maryland / D  Registrar		tment of H ificate of L			iene <sub>eg. No.</sub> 2 ()	09	22195	
			1. Decedent's Name (First, Middle, Last)			-	2. Date of Deat	h	Year	3. Time of Death	_
	Physicia /Medic		Arnold S. Bowling, Sr.				June 25,	2009		4:15 Ам	_
	Examin		4a. Facility Name (If not institution, give street and number) Charles Co. Nursing & Rehab Center		lb. City, Town, or LaPlata	Location of Death		4c. County Char			
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth $214-34-6204$ $1 \frac{1}{3}$ M $2 \square$ F $73$	rhday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 5,	1936	9. Birthi Cou Mar	olace (State or Foreign ntry) Yland	
	ס		Usual Residence of Decedent						1.	10d. Inside City Limits	_
	arylar show	卢	10a. State 10b. County 10c. City, Town							1√2 Yes 2 □ No	
	he M. 28a-f iotifie	ecto	MD Charles La P	Lata	10f. Zip Code		1	0g. Citizen of	What Cou	AL	_
	with 3a or 1 be r		10200 La Plata Road			0646		US		,	
٥	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examiner must be notified at once.	/ Funeral Director	11. Marital Status  1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 3 N		as Decedent of Hi ∕es, specify Cuba ⊒Yes 2M∑No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		ck, White,	can Indian, etc. Thite	_
3-003p	72 hours natural", fical Exe	eted by	3 ☐ Widowed 4 ☑ Divorced Year or Dates:  15. Decedent's Education 16a.		nt's Usual Occupa			16b. Kind of E		dustry	_
1717	d within 7 giene. rr than "i rhe wed	Completed	Elementary/Secondary (0-12)   College (1-4or 5+)		NOT use retired Driver	during most of work  )		Cons	truct	ion	
yland	ld be filed lental Hy ked othe ic event,	To Be C	17. Father's Name (First, Middle, Last) Charles Alfred Bowling, Jr.			18. Mother's Nam Mary Ma	e (First, Middle, M deline H		me)		
ary	shou and N s mar	0 :	19a. Informant's Name/Relationship (Type. Print) 19b.	Mailing	Address (Street a	and Number or Rui	ral Route Number	r, City or Towr	n, State, Zi	p Code)	Ī
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פמ	perm Depa Impo any ii		21. Signature of Funeral Service Licensee			ECHOLS FU Mary's Av				546	
i.	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	- 1	the mode of dyin	ig, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death	
	/Medical Examiner		resulting in death)  Due to (or as a consequence of	of):	2120						_
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10 0	ing Phys After this uneral di	ion: To	27. Manner of Death 1 Solution 1 Solution   28a. Date of Injury (Month, Day, Year)   1 Solution   28b. T	tpatient Time of injury	28c. Injur Worl	4 <b>X</b> _I Nursing H y at k?	ome 5 ☐ Resid			ify)	
DIVISION	or Attencter death irector: n by the i	Certification:	2 Accident investigation 3 □ Suicide 6 □ Could not be 4 □ Homlcide determined building, etc. (Specify)	rm, stree		Yes 2 □No	28f. Location (S City or Town	treet and Nun n, State)	nber or Ru	ral Route Number,	
ב	pital o		29a. Certifier 12 Certifying Physician: To the best of my knowledge	e. death	occurred at the til	me, date and place	and due to the	cause(s) and r	manner as	stated.	_
	ne Hos n 24 h ne Fun bletely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination an and manner stated.								
	To the vithin to the complex c	Me	29b. Signature and title of certifier  MD		29c. Licens	57990	7	29d. Date sign	ed (Month	, Day, Year)	
F	3310		30, Name and advess of person who completed cause of death (Item 23a).  Manisha Tanwaa, MD (163	(Type, Pr	Terrace	e Drive	Ste 103	, Wald	lorf, 1	7 MD 20602	
ľ	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature	5. A	bares						

#### State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician Jane Ellen Burns June 26, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico 30734 Foxchase Drive Salisbury If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/15/1957 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 K F Director 139-50-1269 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nt: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Middeal Examinar must be notified at Director Maryland Wicomico Salisbury 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 30734 Foxchase Drive 21804 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ∐Yes 2 🔀 No If Yes, Give 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No þ Specify: 3 Widowed 4 Divorced Ye ar or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ nurse practitioner health care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Andrew Semko Phyllis Siracuse ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is James Burns/spouse 30734 Foxchase Drive, Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 6/29/09 Salisbury Crematory Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Holfoway Funeral Home Professional Association Kall R X 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) P.0. 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 24a. Was an autopsy performed 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 Natural Injury 5 Pending within 24 hours after death. To the Funeral Director: A completely filled in by the fu investigation 2 Accident

6 Could not be

determined

3 Suicide

29a. Certifier

Medical

4 Homicide

(Check only one)

Name and address of

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

CARROLL ST

28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)

E

and manner stated.

erson who completed cause of death (Item 23a) (Type, Print)

100 trar's Signature 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 D Unknown

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No

3. Time of Death

8:08

Birthplace (State or Foreign Country)\_

10d. Inside City Limits

Approximate Interval Between Onsevand Death

1 ☐ Yes 2 X No

Pennsylvania

white

Year

USA

Black, White, etc.

ма

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 🗗 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

SAUCBURY

09-05318 Laura Bordley

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Í		1- For State Registrar	Certificate of Death	Re	eg. No.
Physicia	n/	Decedent's Name (First, Middle,Last)	0 11 1	Date of Deat     Month	h 3. Time of Death Day Year 1350 bro
Vedical Exami:		Laura Ann	Bordley	July 6, 200	9 13501118
		4a. Facility Name (if not institution, give street and numb Johns Hopkins Bayview Mewdical Center		or Location of Death	4c. County of Death
Euporol			Age (In yrs. last birthday) If Under 1 Y		th(MM/DD/YYYY) 9. Birthplace (State or
Funeral Director		217-84-9983 1 M 2 VF		ays Hours Min. Aug. 2	5. 1966 Country)
		Usual Residence of Decedent		J	10d. Inside City Limits
w any	- 1	10a. State 10b. County	10c. City, Town or Location		1 Yes 2 No
yland -f she	힕	10e. Street and Number	Baltimore 10f. Zip Code	11	Og. Citizen of What Country?
ith the Maryland  23a or 28a-f sho	Director	T1112 1: 1	701. 219 0001	12 "	U.S.A.
A ith th	딅	54/3 Mayview A	Venue 2	Hispanic Origin? (Specify Yes or No	
0036 within 72 hours after death with the Maryland giene. her than "natural", or items 23a or 28a-f she Medical Examiner must be notified at once	Funeral	1 Never Married 2 Married Armed Force		oan, Mexican, Puerto Rican, etc.)	White, etc.
after o	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2		Specify: Black
hours	g	15. Decedent's Education (Specify only highest grade of	during most of working	pation (Give kind of work done life. DO NOT use retired)	16b. Kind of Business/Industry
5-0036 led within 72 hours a lygiene. other than "natura the Medical Examin	Completed	Elementary/Secondary (0-12) College (1-4			transcondation
5-0036 Iled within 77 Hygiene. I other than	탉	17. Father's Name (First, Middle, Last)	Driver	18.Mother's Name (First, Middle, I	Maiden Surname)
	Be (	Thomas Bord	lev	Ellen Mar	ie Johnson
2121 rould be find Mental is marked tic event,	2	19a. Informant's Name/Relationship (Type, Print )		reet and Number or Rural Route Nur	nber, City or Town, State, Zip Code)
e, MD 1 and 2 sho Health and item 27 is	ļ	Ellen Marie Tay	//or 154 John 20b. Place of Disposition (Name of	SON Lane Quee	20c. Location - City or Town, State
of Her tr		20a. Method of Disposition / 1	acomatany or other place)	· .	
Baltimore, permit. Pages 1 a Department of He Important: If ite		4 Donation 5 Other Specify:	Carnichael Cem	etery 1/13/09	Queenstown, MD.
Baltim permit. Pag Department Important: injury or o	١	21. Signature of Funeral Service Licensee	22. Name and Add	FUNERAL HOME, P	ambridge, MD, 21613
Physician	$\dashv$	23a. Par(1. Enter the disease, or complications that cause	sed the death. Do not enter the mode of dy	ng, such as cardiac or respiratory arr	est, shock, or hear? / Approximate Interval
/Medical		failure. List only one cause on each line.	arrhythmia		Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)  Lardiac  Due to (or as a co			
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	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	a of atrioventricul onsequence of): with interst	ar ndal artery a itial fibrosis	ssociated
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Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical Certification: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions  25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined  29a. Certifier (Check only one) 2 Medical Examiner: On the basis of and manner stat 29b. Signature and title of certifier  30. Name and address of person who completed cause Laron Locke MD. Assistant Medical	prisequence of): With interst consequence of):  PT line a-b, # 27 p come of pregnancy that time of death 5 Other (Specify) n eath but not resulting in the underlying cau taken 2 ER/Outpatient 3 DOA linjury ay, Year) 28b. Time of Injury 28c. 1 of Injury - At home, farm, street, factory, offi of my knowledge, death occurred at the time examination and/or investigation, in my opi ed. 29c. Lic O of death (Item 23a)	er ME g893 7/30/  3 Ectopic pregnancy  se given in Part I.  23e. Did to the general source of Death (Check only one)  Other Marsing Home 5 Injury at Work?  Yes 2 No  ce building, etc.  28f. Location (or Town, or Town, death occurred at the time, date ense number  C. M. E.	D9 TT    23d. Date of delivery   Month   Day   Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 21 per DVR G893 7/15/69 GR

State of Maryland / Department of Health and Mental Hygiene 1- State Amend Item 5 per FH G893 7/21 On include of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day 15 **Physician** 2009 1:12 PM June ELMER EUGENE BOWERS /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frederick Frederick Memorial Hospital Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Nov 5 1919 9. Birthplace (State or Foreign Gountry) MD 6. Sex 7. Age (In vrs. last birthday **Funeral** Days Hours  $212 - 03 - \frac{5902}{2080}$ X M 2 □ F 89 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 XYes 2 No Directo MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21701 USA 1493 West 9th Street "natural", or items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married XX Married White If Yes, Give Year or Dates: WW II 1 □Yes 2No Specify. à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Automotive Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Mental Hitem 27 Is marked of Lilly May Hickman Elmer E. Bowers ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9730 Handson Road, Frederick MD 21702 19a, Informant's Name/Relationship (Type, Print) Daughter Cheryl Stull 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 6/19/2009 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem. Grdn. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Keeney & Basford PA FH John A Skarko M01176 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASCVD Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**Physician** /Medical **Examiner** 

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-trar The law requires that the death certificate be page 2 s Hospital or Attending Physician:

Division of Vital Records, P.O. Box 68760

Hypertension			1 ☐ Yes 2 [	] No 3 ☐ Probably 🎞 Unknown
			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
25. Was case referred to medical		26. Place of Dea	th (Check only one)	
examiner? 1 □ Yes 2 <b>X</b> No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	DOA Other: 4 Nursing H	ome 5 ☐ Residence 6	Other (Specify)
27. Manner of Death 1 🏲 Natural 5 □ Pending 2 □ Accident investigatio	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	occurred .
3 ☐ Suicide 6 ☐ Could not to determined		ctory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
29a. Certifier 1⊠ Certifying P (Check only one) 1 □ Medical Exa	hysician: To the best of my knowledge, death occuminer: On the basis of examination and/or investig and manner stated.	urred at the time, date and place ation, in my opinion, death occu	e, and due to the cause(s) arred at the time, date and	and manner as stated. place, and due to the cause(s)
29b. Signature and title of certifier	01/	29c. License number	29d. Date	e signed (Month, Day, Year)

29c. License number D17549

State Registrar

31. Date filed (Month, Day

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

**JUL 13** 

within 2

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Departmen			ental Hygi	ene		
			- State Registrar Certificate	e of Dea	ath		g. No. 🤈 🗍	100	22199
	Physicia	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death	, <sup>2</sup> 2009	Year	3. Time of Death 3:00p M
	/Medic	al	Carlota Cabrera	Town, or Locat		June 21	4c. County		3.00P M
7	Examin	er	,						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under		nder 24 Hrs.	8. Date of Birth		tgor 9. Birth	place (State or Foreign
	Director		579-90-4805 1 M 2 X F 103 Yrs. Months	Days Hou	urs Min.	(Month, Day, 3 / 0 9 / 1 9	06	El S	Salvador
	pu \star		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location						Od. Inside City Limits
	faryla f shor	ō	MD Montgomery Kensington						1 ∐Yes 2★ No
	the N 28a-1 notifie	rect	10e. Street and Number 10f. Zip	Code		10	g. Citizen of \	What Cou	ntry?
	3a or	<u></u>	3107 Plyers Mill Road	20895			USA		
	be flied within 72 hours after death with the Maryland Hygiene.  do other than "natural", or items 23a or 28a-f show event, it all which Examiner must be notified at	Funeral Director	11 Marital Status 12, Was Decedent Ever in U.S. 13, Was Decedent	dent of Hispanicity Cuban, Me	ic Origin? (Spe	ecify Yes or No-		e - Ameri	can Indian,
õ	after or ite	y Fu	1X Never Married 2 ☐ Married 1 ☐ Yes 2 X No	2 □ No Spe		ilidari, etc.)	Specif		
215-0036	ural",	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: E1	Salvad				WII	ite
	"nai"	Completed	(Specify only highest grade completed) (Give kind of wo	rk done during se retired)	most of working	ng l	6b. Kind of B	usiness/ir	dustry
717	withi jiene. r than	шо	Elementary/Secondary (0-12) College (1-4or 5+) Nurs				Med	licai	L
פַ	ould be filed withir Mental Hygiene. arked other than atic event, It of Man	a	17. Father's Name (First, Middle, Last)			(First, Middle, M		ne)	
/land	uld be Wental Irked c	To B	Juan Torres		Carme:	n Cabre	era		
Mary	2 sho and 1 is ma auma		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address				-		
ა ბ	and sealth m 27		Bertha A.Lopez/Daughter 3107 Ply	-				<u>·</u>	
0	iges 1 nt of h If ite or ot		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State		1		Oc. Location	-	
altimor	it. Pa rtmer rtant: njury		4 Donation 5 Other (Specify)  Parklawn Mer		,		Rockv		-
g	permit. Pages 1 and 2 should be Department of Heath and Ment Important: If item 27 is marked any injury or other traumatic eonce.		21. Signaturi uneral Servic Li enset PH Namoral PH Namo	P^D*RI	NALDI	FUNERA	AL SER	VIC	E,P.A. g,Md20910
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mod					/1 1110	Approximate
E	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	oesamaanyas za					Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)  a. Ischemic Cardiomyo Due to (or as a consequence of):	pathy				-	15yrs
	Examiner		Atherosclerotic Ca		ascula	ar Dise	ase		30yrs
	D #	ner	Sequentially list conditions, If any, feating to immediate cause. Enter Underlying Cause (Disease or injury						
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Ď,	icate be executed physician and the burial-transit		resulting in death) Last Due to (or as a consequence of):						
	icate be physicia s the buri	dical	d					-	
X	w requires that the death certifices been signed by the attending should be detached for use as	hysician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy				23d. Da	ite of deliv	verv
POX	death e attel d for u	iciar	in the past 12 months?  1					onth	Day Year
).	t the c by the	hys	9 ☐ Unknown						
ທົ	ss tha gned se det	Jy P	Part II. Other significant conditions contributing to death but not resulting in the underlying of	ause given in F	Part I.	23e. Did tob	acco use con	tribute to	the cause of death?
Hecord	equire	led	Chronic kidney disease stage 3			1 □ Ye	s 2 No	3∏ Pro	bably 4 Unknown
•	law r las be	ple	Hypoproliferative anemia			24a. Was ar autops	/	Were aut	opsy findings available ompletion of cause of
<u> </u>	: The law cate has t page 2 s	Completed by				perform	ned?	death? 1 ☐ Yes	2 🗆 No
VItal	ician certifi ector,	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	Othor		(Check only one			
5	Phys this ral dir	<u>۲</u>	1 Inpatient 2 EH/Outpatient 3 DC			me 5 XReside 28d. Describe ho	_		ify)
0	ding h. After funer	tion	1 X Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation	28c. Injury at Work? 1 ☐ Yes		Edd. Describe no	w injury occur	160	
DIVISION	Atten r deat ctor:	lfica	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory			28f. Location (St	eet and Numi	ber or Rui	al Route Number,
5	al or	Certification: To	4 ☐ Homicide determined building, etc. (Specify)			City or Town	, State)		
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 s		29a. Certifier (Check only)  1 Certifying Physician: To the best of my knowledge, death occurred 2 Medical Examiner: On the basis of examination and/or investigation						
;	the H hin 24 the F riplete	Medical	one) and manner stated.						
	vitl con	2	1 / / / / / / / / / / / / / / / / / / /	c. License num D350		29	9d. Date signe		
9.	3		The T. Smille M.D		<del></del>		June	23,	2009
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Jose Bonelli M.D. 8807 Colesville	5 R C	Silve	r cari-	EM D	2001	1.0
	Sta	te	31. Date filed (Month, Day, Year)	= Mu.	эттле:	r shiii	ig, Ma	209	. 0
	Registr		JUN 26 2009 2 July 6 Souls						

			_ For	State of Ma	ryland / I	•				Mental Hy	/giene			
			<ul><li>State Registrar</li></ul>			Cer	tificate	of E	Peath		Reg. No.	200	0	22200
	Physicia	an	1. Decedent's Name (First, Middle, Las	,						2. Date of D Month	eath L Day	Yea		Time of Death
	/Medic		William James (	Cochrane						June		009		11:43 P <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give	street and number)			4b. City, To	wn, or	Location of Dea	ith	4c. (	County of D	eath	
rd.			9701 Beman Woods				Potom If Under 1		If Under 24 Hr	0 0 0-1(0		ntgom		Ctata ou Faurian
	Funeral		5. Social Security Number 6. S	ex 7.Age ☑M2□F	(In yrs. last bi	Yrs.		Days	Hours Mir	. (Month, E	ay, Year)	C	Country COT 1	e (State or Foreign and
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	/land		10a. State 10b. County		10c. City, Tow	n or Loc	cation						10d.	Inside City Limits
	Mar a-fsh	tor	MD Montgome	ery	Potoma	ıC								1 ☐ Yes 2X No
	or 28	Director	10e. Street and Number				10f. Zip Co	ode			10g. Citiz	en of What	Country	?
	th wit		9701 Beman Woods	Way			2085	4			USA			
	be filed within 72 hours after death with the Maryland that Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Madical Every front in the redthed at	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?,	ver in U.S.	13. V	Vas Deceden Yes, specify	nt of His	sp <i>a</i> nic Origin?	Specify Yes or Norto Rican, etc.)	0- 1	4. Race - A Black, W		Indian,
36	afte , or it		1 Never Married 2 Married	1 ∐Yes 2 ⊒ <b>X</b> N If Yes, Give	0	1	□Yes 2□	<b>X</b> No	Specify:	,		016		
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<b>Q</b>	filled Hygi Sther ent, I		17. Father's Name (First, Middle, Last)	<u>J</u> ,	1 + 1.	Lybra	JIGH		18. Mother's Na	ame (First, Middl				
au	ld be ental ked c	To Be	Nathaniel Cochra	ne				1	Dorothy	DeMarco				
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Heath and Mental Hygiene at the 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, It. Maryles Ever financials by rediffed at	-	19a. Informant's Name/Relationship (		198	o. Mailin	g Address (S			Rural Route Num		Town, Stat	e, Zip Co	ode)
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Ĕ	Page nent int: M		1 □ Burial 2 ♣ Cremation 3 □ 4 □ Donation 5 □ Other (Specify							6/27/09	Wood	lbine,	MD	
Baltimore,	permit. Pages 1 and Department of Heali Important: If item 2 any injury or other		21. Signature of Funeral Service Licen	\$49 /1/1		22	Name and	Addres	s of Facility	ion Serv	rice	P.O.	Box	784
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П		ĺ	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that caused one cause on each lin-	the death. Do	not ente	er the mode of	of dying	ı, such as cardi	ac or respiratory	arrest,		Aş İn	oproximate terval Between
	Physician		Immediate Cause (Final disease or condition	. Metastat	ic Non-	-sma.	ll cel	1 c	ancer					nset and Death months
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687	ficate g phys s the	edical		.d										-
X	nding use a	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of							2	3d. Date of	delivery	
P.O. Box	death e atte d for	Physician/Me	in the past 12 months?	1 ☐ Live birth : 4 ☐ Pregnant at			Ectopic pred Other (spec					Month	Da	y Year
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ω̂.	s tha	by P	Part II. Other significant conditions	ontributing to death bu	t not resulting i	in the ur	nderlying caus	ise give	n in Part I.	23e. Dio	I tobacco us	se contribut	e to the	cause of death?
ğ	aquire en siç ould b	ed								_ 1 💆	Yes 2	]No 3□	] Probab	ly 4 ☐ Unknown
ပ္ပင္ပ	law re as be 2 sho	Completed								24a. Wa	s an opsy	24b. Were	autops)	findings available letion of cause of
œ .	The ate h	E								per 1 □ Yes	formed?	deatl	h? Yes 2	
<u>ta</u>	slan: ertific ctor,	Be	25. Was case referred to medical examiner?						26. Place of D	eath (Check only				
<u>&gt;</u>	hysic his ce		1 Yes 2X No		nt 2 ER/O	utpatien	t 3 DOA	Othe	r: 4 🗆 Nursing	Home 5 ₹Re	sidence 6	Other (5	Specify)	
2	ng Phy After thi Ineral o	ü.	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b.	Time of Injury		c. Injury Work	at ?	28d. Describe	e how injury	occurred		
Sio	tendi eath. for: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be				М		es 2□No	-				
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Certification: To	4 Homicide determined	28e. Place of Inju building, etc	ry - At home, fa . (Specify)	arm, stre	eet, factory, o	office		28f. Location City or To	(Street and own, State)	l Number o	r Rurai F	loute Number,
	oital nurs a eral I		29a. Certifier 1X Certifying Ph	velatary. To the beat				t Ale - Ai		an and due to the		and manna		o.d
	Hos 24 ho Fund Fund Stely 1	Medical		ysician: To the best on niner; On the basis of and manner sta	examination a									
	ithin of the of	Mec	29b. Signature and title of certifier	and marine sta	7		29c. L	License	number		29d. Date	e signed (M	onth, Da	y, Year)
•	- 5 - 0		· 4/~	101			D33	3293			June	26, 2	2009	
7	000		30. Name and address of person who	completed cause of de	eath (Item 23a)	(Type I	Print)							
Í	DEC		Frederick P. Smith	h. M.D. 54			·	#	1300 Ch	evv Chas	se. Mr	2081	5	
P	Sta	te	31. Date filed (Month, Day, Year)	32. Registra	r's Signature		<i>t</i>	. 1/	. 500 011	017 01101				
	Registr	ar	JUNE 9 2	1009 Dinse	a B.	1	arked	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Lena Joan Carter 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ June 25, 2009 1712 hrs Medical Examiner Lena Joan Carter 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3126 Edgewood Drive Ellicott City Howard 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** Foreign Country) MD Davs Min. Months Director Hours 07/24/2007 216 79 2075 1 M 2 XF 1 Usual Residence of Decedent E S 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Yes 2 X No MD Howard Ellicott City be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21043 United States 3126 Edgewood Drive Funeral 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married Armed Forces Yes 2X No Widowed If Yes, Give Year Yes 2 X No specify: White Divorced Specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 N/A n N/AHealth and Mental Hygiene. 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Wendy E. Wilson Daniel A. Carter and 2 should 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) £ Daniel A. Carter/Father 3126 Edgewood Drive Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, Baltimore, 20a. Method of Disposition Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Pages 1 Columbia Memorial Pk. 06/30/2009 Clarksville, MD Donation 5 Other Specify 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee M01044 - White ( à 4112 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Between Onset and 'Medical Death a. Hyperthermia Immediate Cause (Final disease **x**aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and hysician/Medical UNPENDED AMENDED attending physician for use as the burial Division of Vital Records. P.O. Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown ned by the a detached fo ā Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed has been s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy nerformed? death? page ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 examiner? Other; Inpatient 2 Nursing Home 5 Residence 6 ✔ Other: Scene ER/Outpatient 3 DOA this 1 🗸 Yes No uneral 28a. Date of Injury FOUND: 27. Manner of Death After 28b. Time of Injury 28c. Injury at Work 28d. Describe how injury occurred Certification Subject exposed to high environmental FOUND: Natural Pending 1 Yes 2 ✔ No death. Director: temperature Jun 25, 2009 1700 hrs 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City filled in 3 Could not be or Town, State) 3126 Edgewood Drive, Ellicott City, MD determined (Specify) Other (inside vehicle) 24 hours Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 26, 2009 30. Name and address of person who completed cause of death (Item 23a) 1 EG 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) 9 2009

DHMH 17 Rev 1/2001 **OCME 2006** 

State

Registrar

acks

istrar's Signature

		1 - State of Maryland / Department of State of State of Maryland / Department of State of State of State of Maryland / Department of State of S	tificate of Death		g. No. 2009 22202
Physic	ian	1. Decedent's Name (First, Middle, Last)		Date of Death     Month	Day Year 3. Time of Death
/Medi		ROBERT DENNIS COLEMAN		JULY 3,	2009 5:20 P M
Exami	ner	,	4b. City, Town, or Location of Death		4c. County of Death
		5645 CHURCH HILL RD.	If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	QUEEN ANNE S
Funeral Director		5. Social Security Number  6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 7 S8 Yrs.	Months Days Hours Min.	5/16/195	
and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Local	ation		10d. Inside City Limits
//aryl	ō	MD QUEEN ANNE'S CHESTER	RTOWN		1 ☐ Yes 2 🎇 No
the N	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Country?
with Sa or	ā	5645 CHURCH HILL RD.	21620		USA
leath	Funeral	11 Mayital Status 12 Was Decedent Ever in U.S. 13. W	las Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
I'e, Maryland ZIZIS-UU30 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, I'm Medical Extra inpur marks in citiled at	by Fur	1 Never Married 2 Married 1 Tyes 2 M No	Yes, specify Cuban, Mexican, Puerto	Hican, etc.)	Black, White, etc.  Specify: WHITE
Z1Z15-UU36 ed within 72 hours aff giene. er than "natural", or the Medical Execut	Completed	15. Decedent's Education 16a. Decede (Specify only highest grade completed) (Give k	ent's Usual Occupation cind of work done during most of work		6b. Kind of Business/Industry
within iene.	E D	Elementary/Secondary (0-12) College (1-4or 5+)	O NOT use retired)		EDUCATION
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II y lat I o Z I Z ishould be filed within not Mental Hygiene. marked other than imatic event, the Mental control of the Mental control of the Mental other than in a file of the Mental other than th	Be	WILLIAM ARTHUR COLEMAN	BETTY V		,
should I and Men s marke	은		g Address (Street and Number or Ru		City or Town, State, Zip Code)
Maryland nd 2 should be file sith and Mental Hy 27 Is marked oth		· ·	CHURCH HILL RD.		
e, n 1 and Health Hem 27 Hem 27		20a. Method of Disposition  20b. Place of Disposition  20b. Place of Disposition  cemetery, crem			Oc. Location - City or Town, State
ages ent of nt: If it		1 [XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESTER (	i i	2000	CHESTERTOWN, MD
Dallimore, in permit. Pages 1 and Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licensee 22.	Name and Address of Facility ELLOWS, HELFENBEI	N & NEWNA	AM FUNERAL HOME
a au = 60		23a. Part 1. Enter the disease or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	30 SPEER RD. CHES	TERTOWN,	MD 21620 Approximate
Physician / /Medical Examiner	ı		AIN TUMOR,		
g physician and as the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C			
eath cerl attendin	Physician/Me		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
w requires that the dispersion signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tob	acco use contribute to the cause of death? s 2 ∰No 3 ☐ Probably 4 ☐ Unknow
The ate h	Completed				y prior to completion of cause of death? No 1 □Yes 2 □No
Physician: r this certific	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	Othor	th (Check only one	ence 6 ☐ Other (Specify)
ling Phys	ion: To	1 ☐ Yes 27 No	28c. Injury at Work?	28d. Describe ho	
To the Hospital or Attending Ph within 24 hours after death, To the Funeral Director: After th completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, streed building, etc. (Specify)		28f. Location (Sti City or Town	reet and Number or Rural Route Number, n, State)
Hospital or 24 hours afte Funeral Din etely filled in	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death of the	n occurred at the time, date and place vestigation, in my opinion, death occu	e, and due to the curred at the time, do	ause(s) and manner as stated. ate and place, and due to the cause(s)
p P P P	Mec	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Month, Day, Year)
om the		I A NAME MO	D004158	7	7/1/2006
To the P within 2 To the P complet		The state of the s	1007108	/	1161200
V With to mos		30. Name and address of person who completed cause of death (Item 23a) (Type I			1/6/2001
To the within common		30. Name and address of person who completed cause of death (Item 23a) (Type, I Helen A. Noble, MD 122 Speer Rd			670

		,	For State	State of Maryla	and / Dep		lealth an		211	19	22203
	_		Registrar  1. Decedent's Name (First, Middle, Last)			Timeate or i	Dealii	2. Date of Dea	Reg. No. 💪 🔾		3. Time of Death
п	Physici	an						June	18 20	Year <b>O</b> O	11:58A M
-	/Medic		Sallie Coopper	4		45 O't To	al anation of D		4c. County o		11.50K
k.	Examir	ier	4a. Facility Name (If not institution, give s		- 0 2	4b. City, Town, or		Jeath	-		undel
17			Anne Arundel Me  5. Social Security Number 6. Sex		rs. last birthday			Hrs.   8 Date of Birth			place (State or Foreign
и	Funeral			]м 21/27 F	83 Yrs.	Months Days		Hrs. 8. Date of Birth Min. (Month, Day  Une 25	Year) 1925	Cour	ryland
	Director		Usual Residence of Decedent		0.0			ψOne 25	7 1 3 4 3	110.	L J LL MILL
	/land		10a. State 10b. County	10c.	City, Town or Lo	ocation				1	0d. Inside City Limits
	Mary I-f sh	į	Maryland Anne Ar	undel	Annapo	olis					17XTYes 2□No
	r 28g	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of WI	nat Cour	ntry?
	n with	Completed by Funeral Director	701 Glenwood St	. Apt 514		214	01		US	A	
	death	ner	11. Marital Status	12. Was Decedent Ever in	n U.S. 13.	Was Decedent of H	lispanic Origin	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race		can Indian,
9	after or ite	显	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1		1 ☐Yes 21 No	Specify:	derto riicari, etc.,		, White,	
21215-0036	ral",	i by	35 Widowed 4 □ Divorced	Year or Dates:		TENES ZANO	оресну.		Specify:	.8	lack.
5-(	72 h natu	etec	15. Decedent's Educ (Specify only highest grade	cation e completed)	I (Give	edent's Usual Occup	during most of	working	16b. Kind of Bus	iness/In	dustry
21	ithin ne. nan "	ם	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired	d)	_	D D	J	D = = -1-
	filed within 72 hours after death with the Maryland Hyglene. uther than "natural", or items 23a or 28a-f show ont, the Medical Evertiner rivet be notified at		12th	0	Ca	aterer	40.14.4	N. (First Middle	Bay Ri		Beach
Ind	be fil ntal H nd ott	Be	17. Father's Name (First, Middle, Last)					Name (First, Middle,		,	
yla	ould Mer narke	은	Bernard Brashea					F. Barne			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Model Evander traumatic event, the Model Evander to the traumatic angle of the content of the Model Evander.		19a. Informant's Name/Relationship (Ty		ı			or Rural Route Numbe Annapol	-		
	1 and Healt Sm 2		Celie B. Howard  20a. Method of Disposition					Date Date	20c. Location - C		
Ö	ges If of I		1 □X Burial 2 □ Cremation 3 □ R			osition (Name of matory or other place					
Baltimore,	t. Pa rtmer rtant:		4 ☐ Donation 5 ☐ Other (Specify)	1		nd Veter					le, Md.
3al	permi Depar Impor any Ir		21. Signature of Funeral Service License	96				ons Morti			0.1
	0.D = 40 Ot		yavy &, Been	in 8883				Annapolis		214	
			23a. Part 1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the d ne causers n each line.	eath. Do not er	iter the mode of dyir	ng, such as ca	irdiac or respiratory ar	rest,		Approximate Interval Between Onset and Death
-	Physician	İ	Immediate Cause (Final disease or condition	Inev	none	a				1	
	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):						
4	LXammer	_	Sequentially list conditions,	).						-	
	sit	je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons	sequence or):					- 1	
	and and	Examiner	that initiated events resulting in death) Last	Due to (or as a cons	sequence of):						
760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ical E		240 10 (0. 40 4 00	304401100 01/1						
687	hcate phys			l						-	
×	certif oding se as	Physician/Med	IF FEMALE:	3c. If yes, outcome of pre	egnancy				23d. Date	of deliv	orv
Box	atter for u	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time		☐ Ectopic pregnand	у		Mon Mon		Day Year
P.O.	the d y the ched	ıysi	1 □ Yes 2 ☑ No 9 □ Unknown	9 Unknown							
	that the denet by the detached		Part II. Other significant conditions cor	ntributing to death but not	resulting in the I	underlying cause giv	en in Part I.	23e. Did to	obacco use contri	bute to t	he cause of death?
Records,	luires n sign lid be	d by	Emphysen	с.				1 □ Y	es 2 No	3 🗌 Pro	bably 4 🗌 Unknown
00	w requir s been s should	Completed	, V (					24a. Was a	an 24b. W	ere auto	opsy findings available
æ	The law cate has page 2 s	Ĕ						— autop	rmed2 pi	rior to co eath?	mpletion of cause of
Vital	sician: The certificate   rector, page	ပိ	25. Was case referred to medical				OC Place of	1 ☐ Yes F Death (Check only o		∐Yes _	2 □No
5	Physicia this cert al direct	<b>m</b>	evaminer?	lospital:	□ EP/Outpatio	ont 3 🗆 DOA Oth	er.	ing Home 5 Resid		r /Cmaai	<b>4</b> .)
o	y Phy er this eral d	Ĕ	27. Magner of Death	28a. Date of Injury	28b. Time	of 28c. Injur	ry at		now injury occurre		(y)
O	nding F th. : After e funera	ē	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Yea	r) Injury	M 1 □	k?  Yes 2.∐No				
Division	Attend r death sctor: / by the f	Certification: To	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - A	At home, farm, st	treet, factory, office		28f. Location (S	Street and Numbe	r or Run	al Route Number,
Ö	al or s affe I Dire	èrt	4 ☐ Homicide determined	building, etc. (Sp	есну)			City or Tow	m, State)		
	Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director,			sician: To the best of my							
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Examination)	ner: On the basis of exan and manner stated.	mmation and/or i	rivestigation, in my o	opinion, death	occurred at the time,	uate and place, a	na aue t	o ale cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of Certifier	1		29c. Licens	se number		29d. Date signed	(Month)	Day, Year)
	2		1 66 11	MO			551	87	6/11	5/	7
	800	1	30. Name and address of pers who co	mpleted cause of death (	Item 23a) (Type	, Print) /	11	111	1		
	MORE	7	Andoe	/u	Ann	e H	ndel	Medic	« ( «	2 }	-0 v
	Sta Registr		31. Date filed (Month, Day, Year)  JUN 23 20	32. Degistrar's Si	ignature.	have					
			0011 20 20	Comment	1 1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ~2001 - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 4:30 AM 2009 Sarah Louise Crowley June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salisburg Rokabilitation + Nursing Ctr.
5. Social Security Number 6. Sex 7. Age (In yrs. lass birthday Wicomico Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year)

Dec. 26, 1932 Virginia **Funeral** Hours Days Months 1 □ M 2 🛛 F 214-30-9194 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. The properties it flems 73 a marked other than "natural" or items 23a or 28s-f show Important: I flems 73 is marked other than "natural" or items 23a or 28s-f show any injury or other traumatic event, It. Modical Examinations 1 XYes 2 No Director Salisbury Maryland Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21804 206 White Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married しなった。 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: þ 3 ₩ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) homemaker domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jennifer Mumford Charles Bennett ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 206 White Street- Salisbury, Maryland 21804 Kyle Crowley/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Grace Epis. Church Cem. 06/30/2009 Mt. Vernon, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD 21. Signature of Eup 21801 JOLLEY MEMORIAL CHAPEL Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the de th. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause speach line. Immediate Cause (Final disease or condition resulting in death) **Physician** ecen /Medical Due to (or as a consequence of): Examiner 7 on Ri a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burlal-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown icate has been si Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 11No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 1 Ho Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death or Attending Injury 1 / Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation neral Director: A 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral D Hospital 1 🚅 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 1/2001

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200 Civ

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

m.D.

Registrar's Signature

William H. Robin

31. Date filed (Month, Pay, 2009)

1 - State Registrar						Certificate of Death					Reg. No. 2 1 1 9 2 2 2 0 5		
			1. Decedent's Name (First, Mide	dle, Last)					2. Date of D		2000	3. Time of Death	
	Physicia		Ada	Hepnei	_		Creamer		O G	25 Da		7:00 PM	
	/Medic		4a. Facility Name (If not instituti				4b. City, Town, o	r Location of De			. County of Deat		
	Examin	er	COASTAL HOS			8	SALISE				WICOMI		
a dear			5. Social Security Number		7. Age (In yrs. i		If Under 1 Year	,	rs   9 Date of B			hplace (State or Foreign	
и	Funeral			6. Sex 1 ☐ M 2 🖾 F		iasi birinday) Yrs.	Months Days		in (Month, I	Day, Year)	Co	untry)	
	Director		154-18-4425		87	110.			2-3-19	922_	Ne	w Jersey	
	pu s		Usual Residence of Decedent  10a. State 10b. Count		10c Cit	y, Town or Lo	ocation					10d. Inside City Limits	
	sho	-	Tod. State	у								1X Yes 2 □ No	
	r 28a-f show	ctc	MD Wi	comico	5	Salis	bury						
	or 2	ji.	10e. Street and Number				10f. Zip Code			10g. Cit	tizen of What Co	untry?	
	leath wi	a	519 Park Avenu	e			2180	01			USA		
	iter deal	Funeral Director	11. Marital Status	12. Was Dec	edent Ever in U.	S. 13.	Was Decedent of I	lispanic Origin?	(Specify Yes or N	lo-	14. Race - Ame		
9	after or ite	Ŧ	1 ☐ Never Married 2 ☐ Ma	rried 1 Tes	2X No				erio riican, etc.)		Black, White		
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5-0036	72 hours after death with the Maryland "natural", or items 23a or 28a-f show clical Examinet must be notified at	Completed	15. Decede	nt's Education		16a. Dece	dent's Usual Occup	pation		16b. K	(ind of Business/	Industry	
21	= 40	pje	Elementary/Secondary (0-12)	est grade completed	(1-4or 5+)	life.	kind of work done DO NOT use retire	duning most of v d)	vorking				
2121	be filed within tal Hygiene. ed other than "event, the Mere	E	Lietherial y/Secondary (0-12)	5+	(1-401 5+)	Medi	a Special	list		S	chool S	ystem	
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ᇜ	d be ental red c		Martin	Luther		Hepne	r	Ethely	7 <b>17</b>		Pa-	rvin	
≥	houl id M marl mati	ပ္	19a. Informant's Name/Relation			-	ng Address (Street			hor City			
Maryland	d 2 s th ar 7 Is trau				C							•	
	s 1 and 2 should be filed v f Health and Mental Hygi item 27 ls marked other other traumatic event, II		Matthew E. Cre	amer, III			N. Divis:		Date		MaryLand ocation - City or		
0	des 1 t of t t of t if ite		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation	3 □ Removal from	State 20b. P	race of Dispo emetery, cre	osition (Name of matory or other pla	ce)	Date	20c. L	ocation - City or	rown, State	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other tra		4 □ Donation 5 □ Other			endshi	p Finley	UMC¢ 6	-30-2009	Bri	dgeton,	New Jersey	
ä	permit. Departi		21. Signature of Funeral Service	e Licepsee	21	, 2	2. Name and Addre	ess of Facility	Bounds	s Fun	eral Ho	ne	
$\mathbf{\omega}$	B 3 E 6		Milling	Kpoul.	Black	0 7	05 E. Mar	in Stree				and 21804	
			23a. Part. Enter the disease,	or complications that	caused the death	7						Approximate	
/			shock, or heart failure. List Immediate Cause (Final	st only one aus on	each line.	0	0 /	. 5	0			Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	_a.[//L	yelo	dys	plast	e de	mdre	THE		years	
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		_	Sequentially list conditions, b.										
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68760,	certificate be executed ding physician and se as the burial-transit	/Medical		d									
89	tifica g ph as th	ed											
ŏ	ig ej ej		IF FEMALE: 23b. Was decedent pregnant		utcome of pregna						23d. Date of del	ivery	
80	atte for	cja	in the past 12 months?		birth 2 🗌 Feta gnant at time of d		☐ Ectopic pregnand ☐ Other (specify) _	СУ			Month	Day Year	
O.	the d	ysi	1 □Yes 2 🖬 No 9 □ Unknown	9 □ Unk			(-,)/ _						
σ.	w requires that the death cer s been signed by the attendir should be detached for use	Completed by Physician	Part II. Other significant condi	tions contributine to	eath but not resu	ulting in the u	nderlying cause giv	ven in Part I.	23e. Dio	tobacco	use contribute to	the cause of death?	
Š	ires sign	ğ	Sec. I	:0 W	4pm	500	2 2		1.5	7 Vac 2	No 3 P	obably 4 Unknown	
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ec	law las b 2 st	e de		···					24a. Wa	is an lopsy	24b. Were au	topsy findings available completion of cause of	
<b>C</b>	The ate h	E O							pe	formed? 2 X No	death?	completion of cause of	
ta	an: tiffica tor, p	BeC	25. Was case referred to medic	al				26 Place of [	Death (Check only		100	2,000	
>	/sicl		examiner? 1∐Yes 2 <b>∑</b> No	Hospital:	Inpatient 2	EB/Outnatie	nt 3 DOA Oth		g Home 5 □ Re		6 MOther (Sno	oin Haspiel	
Division of Vital Records,	Physical controls	Ë	27. Manner of Death	28a. Date	e of Injury	28b. Time o	of 28c Inju	rv at	28d. Describ			City) 112 J	
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<u>≥</u>	or A	ŧ	4 ☐ Homicide deter	mined 286. Place build	ding, etc. (Specif	y) y)	reet, factory, office		City or T	own, State	na wumber or Hi e)	ural Route Number,	
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	losp t hou une ely fi	cal	(Check only 2 Medica	<b>ing Physicia</b> n: To th a <b>i Ex</b> amin <b>er</b> : On the	ne best of my kno basis of examina	wledge, deat tion and/or in	th occurred at the to	ime, date and pl opinion, death o	ace, and due to to ccurred at the tim	ne cause(: e. date an	s) and manner as nd place, and due	s stated. e to the cause(s)	
	To the Hospital or Attending Physician: The law within 24 burns after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Medical Certification: To	one)	and ma	nner stated.		J, 117 111y	,					
	Vith To t	Σ	29b. Signature and title of certif	er	20 (	2	29c. Licens				ate signed (Mont		
	1		Superal)	h. 1501	War -	la -	DZ	9505	- Careta	06	6-26	-09	
	- Net	ł	30. Name and address of person	n who completed cau	use of death (Item	n 23a) (Tvne	Print)					-	
	1111		GREGORION					BERBY	TR CAL	{ C 12 :	DV NI	TIENT	
	Sta	· o	31. Date filed (Month, Day, Yea	r) - 32.	Registrar's Signa	iture .	/ CITINA	ruy(/	PN; >AL	.1 > D U	LN 7, 141)	/ 410U)	
	Registr			9 2009	Registrar's Signa	1. 1	Sevel						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 200 9 Margaret E. Cash /Medical County of Death scility Name (If not institution, give street and number) 4b. City, Jown, or Location of Death Examiner Comico If Under 1 Year If Under 24 Hrs. HOSDICE Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Year) Months Days Hours Min 1 □ M 2 🖾 F Yrs 81 Director 218-20-9428 April 8, 1928 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show ir than "natural", or items 23a or 28a-f sho TXX Yes 2 □ No Director MD Worcester Snow Hill 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 214 South Washington Street 21863 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★ No 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 ▼ Married 21215-0036 If Yes, Give Year or Dates t □Yes 2X No Specify 2 Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Food Service 11 Cafeteria Assistant Saltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be t and 2 should be fill Health and Mental H ဥ Edward Adkins Lola Oxenford and I 19a. Informant's Name/Relationship (Type. Print) (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 214 South Washington Street Snow Hill, MD 21863 John Gregory Cash, Jr. Important: If item 2 any Injury or other Once. or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 of June 28, 2009 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Spence Baptist Church Cem. Snow Hill, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Eacility
Short Funeral Home East Grove Street Delmar, DE 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Oan /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760, Physician/Medical attending p IF FEMALE: ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Day Year signed by the a d be detached for 5 ☐ Other (specify) ☐Yes 2 No 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, 2 2X No 3 Probably 4 Unknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has certificate Division of Vital 2 No 1 TYes 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at After 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No spital or Attendi ours after death. neral Director: A investigation 2 Accident 3 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled Hospital to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 06-26-09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREGORIO M. BELLOSO, M.P.; 5302 CHINABERRY DR. SALISBURY, MD

DHMH 17 Rev 1/2001

State Registrar 32 Registrar's Signature

		-	Please	e Type or Prir State of Ma					. Ensure A lealth and N			egible.		
	•	for State Registrar			,				Death	,	Reg. No.	anno	2220	7
D		1. Decedent's Nam	e (First, Middle, L	_ast)						2. Date of De		OYAR	3. Time of Death	1
Physicia /Medic		Harriet	Cook							April	25 <sup>ay</sup>	2 0 0	9 6:46	1
Examin	er	4a. Facility Name (i		nive street and number) a1				Ran	r Location of Death dallstown		4c. 0		re County	
Funeral Director		5. Social Security N 217–22–3	791	Sex 7. Ag 1 □ M 2 🖾 F	e (In yrs. la 97	ast birthday) Yrs.	If Unde Months	r 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D Feb. 2	ay, Year)	0	rthplace (State or Forei Country) MD	ηn
and w		Usual Residence of 10a. State	Decedent 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limit	s
Mary -f she	tor	MD	Baltim	ore	]	Randa1	.1sto	vn.					1 ☐ Yes 2 🔼 N	0
h the	Director	10e. Street and Nu	mber				10f. Zi	Code			10g. Citiz	en of What C	ountry?	
23a (23a Lest E	rai	3425 Ch	atman Ro	ad					21133			USA		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time ZT is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evantine Injury or other traumatic event, I'm Medical Evantine Injury or other traumatic event, I'm Medical Evantine Injury or other traumatic event, I'm Medical Evantine Injury or other traumatic event, I'm Medical Evantine Injury or other traumatic event, I'm Medical Evantine Injury or other traumatic event, I'm Medical Evantine Injury or other traumatic event, I'm Medical Evantine I injury or other traumatic event, I'm Medical Evantine I injury or other traumatic event, I'm Medical Evantine I injury or other traumatic event, I'm Medical Evantine I injury or other traumatic event, I'm Medical Evantine I injury or other traumatic event, I'm Medical Evantine I injury or other traumatic event, I'm Medical Evantine I injury or other traumatic event, I'm Medical Evantine I injury or other traumatic event, I'm Medical Evantine I injury or other traumatic event, I'm Medical Evantine I injury or other	by Funeral	11. Marital Status 1 ∰ Never Marr 3 ☐ Widowed	ied 2□ Married 4□ Divorced	12. Was Decedent Armed Forces? 1 □ Yes 2 ☑ If Yes, Give Year or Dates:					tispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Pican, etc.)		Black, Wh	nerican Indian, ite, etc. Black	
n 72 hou "natura	Completed		15. Decedent's cify only highest of	grade completed)		16a. Dece (Give life.	dent's Usu kind of wo	ork done	during most of worl	king	16b. Kir	nd of Busines	s/Industry	
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ld be filed lental Hyg <b>ked othe</b> ic event,	To Be C	17. Father's Name	(First, Middle, La	st)					18. Mother's Nam unk	ne (First, Middle	e, Maiden S	Surname)		
shou and M s mar	-	19a. Informant's N	ame/Relationship	(Type. Print)		19b. Mailir	ng Addres	s (Street	and Number or Ru	ral Route Numi	ber, City or	Town, State	Zip Code)	
and 2 ealth a		Baltimor	e City H	ealth Dept					Street,	Baltimo				
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rmit. spartn porta ny inju		21. Signature of Fu							ess of Facility T				ome	
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ficate be executed physician and s the burial-transit	dical Examiner	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated event resulting in death)	S	Due to (or as  c.  Due to (or as  d.										
The law requires that the death certificate ate has been signed by the attending physioage 2 should be detached for use as the t	Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2 9 □ Unknowr	months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 🗌 Fetal	death 3	⊒ Ectopic ⊒ Other (≲		су		2	23d. Date of o	elivery Day Year	
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w requires t s been signi should be	lete									24a. Wa:	s an	24b. Were	autopsy findings availat	ole
The lay te has age 2	Completed			-						_ per	opsy formed?	prior to death	o completion of cause o	f
ian:   rtifica tor, p	Φ	25. Was case refe	rred to medical						26. Place of Dea	1 ☐ Yes th (Check only		1 □ Ye	es Z INO	
nysici nis ce direc	To B	examiner? 1 ☐ Yes 2 🔣	]No	Hospital: 1 ☐ Inpati	ent 2 🗆	ER/Outpatie	nt 3 🗆 D	OA Oth	ner: 4 🗆 Nursing H	ome 5KL Res	sidence 6	Other (S	pecify)	
nding PP uth. r: After the funeral		27. Manner of Dea ↑ Natural 2 □ Accident	th 5 Pending investigat	28a. Date of Inju (Month, Da	ury ay, Ye <i>ar)</i>	28b. Time o Injury	of M	28c. Inju Wor 1 🗆	ry at 'k? ]Yes 2 □ No	28d. Describe	how injury	occurred		
To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director. After this certificate ha completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not determine				reet, facto	y, office			(Street and own, State,		Rural Route Number,	
ne Hospi n 24 hou ne Funer sletely fill	Medical	29a. Certifier (Check only one)		Physician: To the best caminer: On the basis of and manner st	of examina									
To the within To the Comp	Me	29b. Signature and	title of certifier	MADO	1/2			0c. Licens 01587	se number 7 2		29d. Dat	e signed (Mo	nth, Day, Year)	
		30. Name and add Harold I	ress of person who by MD	no completed cause of o 25 Main Str	eet,	Reist	Print) erst	own M	1D 21136		C			
Sta Registr		31. Date filed (Mor	nth, Day, Year)	32. <b>F</b> egisti	rar's Signat	ture A	ak	1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** 0057  $A^{M}$ 2009 James William Craig, Jr. Ju1v /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ceci1 E1kton Union Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 🗓 M 2 🗆 F 9, Yrs NOV 1948 Mary land 60 220-52-2951 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Eventions must be applied. 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Directo E1kton Maryland Ceci1 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21921 United States 423 Elk Mills Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No If Yes Give Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT, use retired) Elementary/Secondary (0-12) College (1-4or 5+) Foreman/ Excavating and Paving Heavy Equipment Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James W. Craig, Sr. Margaret Kennedy ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 423 Elk Mills Road, Elkton, MD Fay L. Craig/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cherry Hill
Methodist Cemetery 20c. Location - City or Town, State Date 20a. Method of Disposition July 8, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 Cherry Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, 21. Signature of Funeral Service Licensee 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 8 disease or condition resulting in death) /Medical Due to (or as a consequence of) Obstruction Examiner Bawe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9 I Inknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 🔼 No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Malgutritica autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 □ No Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ical completely (Check only and manner stated within 2.

State Registrar 29b. Signature and title of certified

31. Date filed (Month, Day,

A

Year)

30. Name and a rress of person who completed cause of death (Item 23a) (Type, Print)

V4100

32. Registre's Signature

DHMH 17 Rev 1/2001

**ORIGINAL** 

thespital

29c. License number

100

0055190

29d. Date signed (Month, Day, Year)

Bow Street, Elkton 40 21921

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=			Registrar  1. Decedent's Name (First, Middle, Last)	*	<i>CC</i>	mouto or		2. Date of De		Year	3. Time of Death
	Physicia /Medic		Janet	Dy	HUS	)		June	26	2009	627A M
	Examin	er	4a Facility Name (If not institution, give s	treet and number)	4	S. Ico	r Location of Death		46. 60	unty of Death	11
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. In		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	y, Year)	9. Birth	place (State or Foreign intry)
ч	Director		187-26-4541	M 2∏F 75	Yrs.	violitio Bayo	, iouio	08/18/	1933	Penn	nsylvania
	yland ow at		10a. State 10b. County	10c. City	, Town or Loca	tion					10d. Inside City Limits
	e Mar 3a-f sh tified	Director	MD Allegan	У	Cumb	erland			10 000	()4# + 6	1 X Yes 2 □ No
	with the		10e. Street and Number  19 Sunset Dri	V.A.		10f. Zip Code	21502		rug. Chizen	of What Cou	intry :
	death ms 23 r must	Funeral		12. Was Decedent Ever in U.S Armed Forces?	S. 13. Wa		Hispanic Origin? (Span, Mexican, Puerto	pecify Yes or No	14.	Race - Amer Black, White	
36	be filed within 72 hours after death with the Maryland Hygiene. dithyligher dictions 23a or 28a-f show dictier than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at		1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give		Tes, specify out		7 Houri, 010.)		ecify:	
21215-0036	hours atural"	ed by	3 ☐ Widowed 4 【XDivorced 15. Decedent's Educ	Year or Dates:	16a. Deceder	nt's Usual Occup	pation		16b. Kind	of Business/l	White ndustry
215	thin 72 e. an "na Medio	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)			during most of word	king			n.
121	filed wi Hygien ther th		12 17. Father's Name ( <i>First, Middle, Last</i> )	2	P	lccounta	18. Mother's Nam	ne (First, Middle		unting <sub>rname)</sub>	Firm
auc		To Be	Reginald	Ro	wley		Elizabe		Mae	•	Dixon
Maryland	a s a	<b>-</b>	19a. Informant's Name/Relationship (Type John R. Duffus /	,	•	,	and Number or Ru wn Drive				
ce,	es 1 and 2 of Health fitem 27 or other tra		20a. Method of Disposition 1 ☐ Burial 2 🎖 Cremation 3 ☐ R	20b. P	lace of Disposit emetery, crema	tion (Name of atory or other pla	ace)	Date	20c. Locat	ion - City or	Town, State
altimore,	. Pages tment of I tant: If ite		4 □ Donation 5 □ Other (Specify)	Cum			cory 06/2			erland	·
Bai	permit. Pages Department of Important: If it any injury or o		21 Sign rure of Funeral Service License	ldans	40	04 Decat	ur Stree	t, Cumb	erland		Home, P.A. 21502
			23a. Part 1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	cations that caused the death				or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a conse		ment	19				years
	Examiner		Sequentially list conditions	)							
	pe pe pe pe pe pe pe pe pe pe pe pe pe p	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Due to or as a consequ	uence of):						
Ć,	execur n and ial-trar	Exan	that initiated events cresulting in death) Last	Due to (or as a consequ	uence of):						
8760,	cate be executed physician and the burial-transit	dical	d	1							
Ó	leath certific attending p I for use as 1	/Mec	IF FEMALE:	3c. If yes, outcome pf pregna	ancy			-	230	d. Date of deli	iverv
Bo	death e atten d for u	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	l death 3□E	Ectopic pregnand Other <i>(specify)</i> _	су			Month	Day Year
P.0	at the I by the	Phys	9 🗆 Unknown	9□Unknown		ladidas anuas ai	iven in Dort I	22a Did	tobacca usa	contribute to	the cause of death?
ds,	The law requires that the death certificate has been signed by the attending I page 2 should be detached for use as	y py	Part II. Other significant conditions con	imputing to death but not resi	uiting in the unc	ienying cause gi	veiriii Faiti.				obably 4 Munknown
COL	w requ	Completed						24a. Wa		24b. Were au	topsy findings available
<b>B</b>	The la	omo						auto peri 1∐ Yes	opsy formed? 2 A No	death? 1 ☐ Yes	completion of cause of 2 ☐ No
/ita	ician: sertifica setor, I	Be	25. Was case referred to medical examiner?	Hospital:		0:	26. Place of Deather:				
0	Physi r this c ral dire	은	1 ☐ Yes 2 ☐ No	28a. Date of Injury	ER/Outpatient 28b. Time of	3 □ DOA □	4 Linursing F	lome 5 ☐ Res 28d. Describe			cify)
on	nding ath. r: Afte e fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		ork? ∃Yes 2⊟No				
Division or Vital Records, P.O. Box	al or Atte after des I Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At he building, etc. (Specifical Control of the control of	ome, farm, stree	et, factory, office		28f. Location City or To	(Street and I own, State)	Number or Ri	ural Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of my known of the basis of examination and manner stated.	owledge, death ation and/or inve	occurred at the estigation, in my	time, date and plac opinion, death occ	e, and due to th urred at the time	e cause(s) a e, date and p	nd manner as lace, and due	s stated. e to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier				nse number				h, Day, Year)
	10		1/1/2	MD			0062791		61	26/00	<u> </u>
	nes		30. Name and address of person who co		n 23a) (Type, P	RO, Syl	esuale, 1	ND 217	84		
3		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa		,					

Box 68760. P.O. of Vital Records, Division

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Yeuneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ری noss State

31. Date filed (Month, Day, Year) JUN 2 5 2009

AJBOILING

29b. Signature and title of certifier

5 Pending investigation

6 Could not be

27. Manner of Death

1-Natural

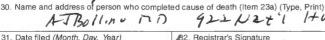
2 Accident 3 Suicide

4 Homicide

(Check only one)

29a. Certifier

Medical



and manner stated.

28a. Date of Injury (Month, Day, Year)

9221241

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 🚾 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

00017565

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

ene24, 2009

82. Registrar's Signature

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10a,b,c,e,f per inf g894 8-6-09 vt. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar AMEND#23a(c)+LiperMD, 6/26/09, BMN, Mo@ertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death June 20, Day 2009 Year **Physician** 9:55 P.M Bernard DINGENTHAL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Suburban Hospital Bethesda 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth July 17, 1926 6. Sex **Funeral** Min. 1**∑** M 2□ F Months Days Hours New York 82 055-18-2227 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dypartment of Health and Mental Hygiene. Inportant: if them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinar mast be mutilised at once. 10b. County Montgomery 10a. StateMD. 10c. City, Town or Location 10d. Inside City Limits 1 ⊈Yes 2 ☐ No Rockville Leesburg 10g. Citizen of What Country? 10e. Street and Number 1801 10f. Zip Code Jefferson 20852 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Draftsman/Engineer US Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Weiss Esther Isidore Dingenthal ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19385 Cypress Ridge Terr., #320, Leesburg, Va 20176 19a. Informant's Name/Relationship (Type. Print)
Gertrude Bergman / sister 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Beth David Mem. Gdns. June 20c. Location - City or Town, State Date 2009 Hollywood, FL S Other (Specify) 4 Donation 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part 1. Enter the disease, or complix tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory **Physician** disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to initial solutions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Pneumonia attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed to hours after death.

Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit. Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy perform Heart failure 2 **M**o 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☑ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the Hosp within 24 ho To the Fune completely f (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 066066 29b. Signature and title of certifier awo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wong 8600 Old Georgetown Rd., Bethesda, MD 20814 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Amend #26 per Phy 6/22/09 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AA Co. HEALTH LO State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death June 17, 2009 **Physician** 8:45 РМ Rocco J. Demilio /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Baltimore Washington Medical Center Glen Burnie If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year Jan. 23, 1 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □XM 2 □ F 81 070-20-4327 1928 New York Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it. "Actics Exa. In must be multiple and any Injury or other traumatic event, it." 1 ☐ Yes 2(XNo Director Crofton Anne Arundel MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21114 USA 1519A Crofton Parkway Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White þ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Wholesale Plumbing 12 Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Virginia Zarillo Rocco Demilio ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0000 19a. Informant's Name/Relationship (Type. Print) 1519A Crofton Parkway Crofton, MD 21114 Jacqueline A. Demilio / wife Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Gate of Heaven Cem. 6/24/2009 Silver Spring, MD 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Insee prio Bowie, MD 6512 NW Crain Hwy 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** 5484NS 91 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affect death.

To the Funeral Director: Affer this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burfal-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Nursidence 6 Other (Specify) 1 Tes AMINo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 X DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) end manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 84

State Registrar Hohardle

31. Date filed (Month, Day, Year) Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

ysician Iedical		- State RegistrarAmended  1. Decedent's Name (First, Mi  Dennis B.  4a. Facility Name (If not institute)	iddle, Last) <b>Derricks</b> o	on				Location of Deat	2. Date of De Month	28 .	Year 200 9	3. Time of Dea 0259
aminer		01 1	ANNAL MED	N	ntel	4D. Oity,	341	136411			Vicom.	
eral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Unde Months	r 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bii	th ev. Year)	9. Birl	thplace (State or Fo.
ctor		222-30-3553	1 <b>★</b> M 2□ F	62	Yrs.	MOITHS	Days	riours IVIIII.	11/23/1	946	Del	aware
	- 1-	Usual Residence of Decedent 10a, State 10b, Cou		10c. Ci	ty, Town or Lo	cation						10d. Inside City Li
ed at		_	ssex		Bridgev							1 <b>X</b> Yes 2□
be notified Director	-	10e. Street and Number	JOCA		DI IUGE	10f. Zi	p Code			10g. Citizer	n of What Co	ountry?
st be		310 Laws St	reet			1	9933				U.S.A.	•
any injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director		11. Marital Status	12. Was De	ecedent Ever in U Forces?	l.S. 13.	Was Dece	dent of His	spanic Origin? (S n, Mexican, Puerl	specify Yes or No	)- 14.	Race - Ame Black, White	erican Indian,
		1 Never Married 2 N	Married 1 → Ye	s 2∐No Give		n Tos, spo 1 □ Yes		Specify:	0 1 110411, 0101,		pecify:	112
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t, the Medical E Completed		15. Dece (Specify only hig	dent's Education ghest grade complete	d)	16a. Dece	dent's Usu kind of wo DO NOT u	ork done d	uring most of wor	rking	16b. Kind	of Business/	Industry
S C C		Elementary/Secondary (0-1	2) College	e (1-4or 5+)			_ ′	rator		Hob	by Sto	re
at.		17. Father's Name (First, Mide	dle, Last)			HUL	/ OPC	18. Mother's Nar	me (First, Middle	1		
c even	1	Ernest M. D						Rana	Smith			
To	-	19a. Informant's Name/Relati			19b. Mailin	ng Addres	s (Street a	and Number or Ri		per, City or T	own, State,	Zip Code)
r tra		Patricia A.	Hamstead /	Sister	412 N	l. Ph	illip	s St.,	Seaford	DE	19973	
to	ľ	20a. Method of Disposition		20b.	Place of Dispo cemetery, crer	sition (Na	me of other place	e) !	Date	20c. Loca	tion - City or	Town, State
יל		1 X Burial 2 ☐ Cremati 4 ☐ Donation 5 ☐ Othe		m state i				ery 07/	02/2009	Brid	gevil:	le, DE
声	t	21. Signature of Funeral Serv	vice Licensee		2:	2. Name a	nd Addres	s of Facility P	arsell		_	
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ache		9 Unknown	9 L Ur	nknown								
<u>۾</u>	2	Part II. Other significant con	ditions contributing to	o death but not res	sulting in the u	ınderlying	cause give	en in Part I.	1	tobacco use Yes 2□		o the cause of deat Probably 4 🔲 tonk
									perf	s an opsy ormed? 2 No	prior to death?	utopsy findings ava completion of caus s 2 2 No
rector, page		25. Was case referred to med examiner?							ath (Check only	one)		
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led in by the funeral dir		E C 1 looldoile	nding (M	ate of Injury fonth, Day, Year)	28b. Time o	М		yat ?? Yes 2 □ No	28d. Describe			
		4 ☐ Homicide de	termined 286. Pla	ace of Injury - At h uilding, etc. (Spec	ify)				City or To	iwn, State)		Rural Route Number
Medical	1000	29a. Certifier (Check only one) 2 Med	ifying Physician: To ical Examiner: On th and m	the best of my kn e basis of examin nanner stated.	owledge, dea ation and/or in	nvestigatio	n, in my o	pinion, death occ	e, and due to the time	, date and p	lace, and du	e to the cause(s)
1		29b. Signature and title of ter	rtifier				9c. Licenso					th, Day, Year)
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n la	-		son who completed c									

			For State Registrar	State of Ma	ıryland		artment of F rtificate of			giene Reg. No.	2009	22	214	
			1. Decedent's Name (First, Middle, Las	st)					2. Date of De Month	ath Day	Year	3. Time	of Death	
	Physicia /Medic		William Hurst Ei	senberger					6/2	5/200	09	3:3	5pm <sup>M</sup>	
a Company	Examin		4a. Facility Name (If not institution, give				4b. City, Town, o	r Location of Deat	h 4c. County of Death					
-			12210 Henry Driv	е			Cumber				Allega			
	Funeral		Social Security Number     6. S	ex 7.Age XDM 2□F	(In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da	th ay, Year)	Cour	olace (State otry)		
и	Director		210=22=1190	AJWI ZLI F	82	Yrs.			March 2	0, 19	927Washi	ngton	, D.C	
	pu .		Usual Residence of Decedent  10a. State 10b. County		10c. City, 7	Town or Lo	cation				1	0d. Inside	City Limits	
	sho sho	'n	MD Allega	nv			nd, MD					1 □Ye	s 2XNo	
	he M	ect		,	Odin	001 14	10f. Zip Code			10a Citia	zen of What Cour	atry2		
	with t	吉	10e. Street and Number 12210 Henry Dri	V.A.			2150	2			JSA	10. <b>y</b> 1		
	s 23	Funeral Director		12. Was Decedent E	uer in II C	12			Specify Ves or No		4. Race - Americ	an Indian		
	er de item ner r	Ë	11. Marital Status	Armed Forces?		13.	Was Decedent of I If Yes, specify Cub	an, Mexican, Puer	to Rican, etc.)	´   '	Black, White,			
36	rs aft	þ	1 ☐ Never Married 2√☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 <b>Y</b> □Yes 2 □ N If Yes, Give Year or Dates:	MINTT		1 □ Yes 2√∑ No	Specify:			Specify: Whi	te		
21215-0036	hou	Completed by	15. Decedent's Ed			16a. Dece	dent's Usual Occup	pation		16b. Kir	nd of Business/In	dustry	-	
15	in 72 n "ne Nedit	plet	(Specify only highest gra	de completed)		(Give life.	kind of work done DO NOT use retire	during most of wo d)	rking					
212	I with giene r tha	E	Elementary/Secondary (0-12)	College (1-4or 5- ∐	+)		Advertis	ing		I	Rubber			
D	filed I Hyg othe	Be C	17. Father's Name (First, Middle, Last)				AUVEL UID.	18. Mother's Na	me (First, Middle	, Maiden S	Surname)			
a	ild be lenta ked ic ev	To B	William Albright	Eisenberg	er			Mabel (	Woodring	) Eis	senberge	r		
Maryland	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show is marked other than "natural".		19a. Informant's Name/Relationship (	Type. Print)		19b. Mailii	ng Address (Street	and Number or R	ural Route Numb	er, City or	Town, State, Zip	Code)		
2	nd 2 alth a 27 is r tra		Shirley Eisenberger / wife 12210 Henry Drive, Cumberland, MD 21502											
ē,	s 1 a f He item othe		20a. Method of Disposition		20b. Plac	ce of Dispo	sition (Name of	1	Date	20c. Lo	cation - City or To	own, State		
The state of the s									26/2009	Cumb	perland,	MD		
Ħ	mit. I		21. Signature of Funeral Service Licer			22	2. Name and Addre	ess of Facility A	dams Fam	ilv E	Tuneral	Home		
ä	21. Signature of Fyneral Service Licensee  22. Name and Address of Facility Adams Family Funeral Service Licensee  404 Decatur St., Cumberland, MD 2													
			23a. Part 1. Enter the disease, or com	plications that caused	the death.	Do not en	ter the mode of dyi	ng, such as cardia	ac or respiratory a	arrest,		Approxim Interval B	ate etween	
	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each lin		1 1	4.4					Onset an	d Death	
	/Medical		disease or condition resulting in death)	a. 250011 Due to (or as a	-		u Ciron					() M	<u>, 'n</u>	
	Examiner			200 10 (01 00 0										
		je.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of): ause. Enter Underlying ause (Disease or injury hat initiated events esulting in death) Last  b. Due to (or as a consequence of):  accomparison of the consequence of th										
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury	0										
Ć,	exec in an ial-tn	Еха	resulting in death) Last	Due to (or as a	a conseque	nce of):								
68760,	icate be executed physician and s the burial-transit	ical		d										
9	tifica ig ph as th	ledi												
Box	eath certific attending p for use as	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			☐ Ectopic pregnan	CV		2	23d. Date of deliv			
-	deat e ath	icia	in the past 12 months? 1 □Yes 2 □No	4 Pregnant at			Other (specify)	Су			Month	Day	Year	
P.0	that the dended by the detached	Physician/Med	9 Unknown	9 🗆 Unknown										
	s tha		Part II. Other significant conditions of			ing in the u	nderlying cause gi	ven in Part I.	23e. Did	tobacco u	se contribute to t	the cause o	f death?	
Ë	quires en sign uld be	Completed by	Cerebrosascular	. accide	it				1 🗆	Yes 2€	No 3□ Pro	bably 4	] Unknown	
S	aw requires been so should	olet	Cheoniz Gidie	y Disease					24a. Was		24b. Were auto	opsy finding	s available	
æ	The law te has age 2 :	mo					_		auto perf	ormed?	death?	ompletion o	cause of	
ta	an: ] tiffica tor, p		25. Was case referred to medical		<del></del>			26. Place of De	eath (Check only		I Lores	2 (2110)		
of Vital Records,	ding Physician: The In. After this certificate hat funeral director, page	o Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Innatie	nt 2□EF	R/Outpatie	nt 3 DOA Ot	hori	Home 5 Res		S ∏Other (Spec	ifv)	-	
o	a Physer this	n: To	27. Manner of Death	28a. Date of Injui (Month, Day		8b. Time o			28d. Describe					
Division	th.: After	ţi	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		v, Year)	Injury		rk? ]Yes 2. □No						
/isi	Atter	tic	3 ☐ Suicide 6 ☐ Could not b	1 20e. Place of mid	ry - At hom	e, farm, sti	reet, factory, office		28f. Location	(Street and	d Number or Rur	al Route No	umber,	
Ö	alor s afte I Dire	Certification:	4 ☐ Homicide determined	building, etc	. (эреспу)				City or 10	wn, State,	,			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying Pt	nysician: To the best of	of my knowl	edge, dea	th occurred at the	time, date and place	ce, and due to the	e cause(s)	and manner as	stated.	2/2)	
	n 24 n 24 ne Fu	Medical	(Check only 2 ☐ Medical Examone)	niner: On the basis of and manner sta		on and/or in	ivestigation, in my	opinion, death occ	curred at the time	, date and	place, and due t	the cause	2(2)	
		Me	29b. Signature and title of certifier	0				se number			e signed (Month,	Day, Year,		
	5		Christoolen	25/20	uni	nes	I	0059987		6/	26/2009			
			30. Name and address of person who	completed cause of de	eath (Item 2	23a) (Type,	Print)							
	nos		Christopher Vagno					nberland,	MD 215	02				

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

JUN 26 2009

32. Registrar's Signature

Physician /Medical Examiner

Physician

Examiner

**Funeral** 

Director

28a-f show

items 23a or

Director

Funeral

2

Completed

Be

၉

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

injury or other traumatic event, the Modical Examiner must be notified at

/Medical

10a. State

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

19a. Informant's Name/Relationship (Type. Print)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)   1758 Baltimore Annapolis Blvd., Annapolis, MD											
	Mary Lee Evans/daughter	1758	Baltim	ore Annapol:							
	20a. Method of Disposition	20b. Place of Disp cemetery, cr	position (Name rematory or oth	of er place)	Date 20c.	Location - City or	Town, State				
	1 ▼Burial 2 □ Cremation 3 □ Removal from Stat 4 □ Donation 5 □ Other (Specify)	St. Anne	e's Cem	etery   6/2	4/2009 Ar	napolis	, Maryland				
	21. Signature of Funeral Service Licensee	'///		Address of Facility Jo	_						
	Toda e M	ele !	147 Duk	e of Glouce	ster St., A	nnapolis					
	23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each		enter the mode	of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death				
	Immediate Cause (Final disease or condition	ment	na				yeur				
	resulting in death)  Due to (or a	s a consequence of):					9				
_	Sequentially list conditions, b.										
ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	s a consequence of):									
xan	that initiated events resulting in death) Last  C	s a consequence of):									
<u>e</u>	To be to (b) as a consequence of).										
gi	d										
Completed by Physician/Medical Examiner	IF FEMALE: 23c. If yes, outcom					23d. Date of de	elivery				
icial	in the past 12 months?	at time of death	3 □ Ectopic pre 5 □ Other <i>(</i> s <i>p</i> e			Month	Day Year				
hys	9 Unknown 9 Unknown										
Σ	Part II. Other significant conditions contributing to death	but not resulting in the	underlying cau	se given in Part I.			o the cause of death?				
be	COF	0/			1 ☐ Yes	2□No 312F	robably 4 🗌 Unknown				
plet					24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of				
ĕ					performed?	death?	s 2□No				
25. Was case referred to medical examiner?											
										cal Certification: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Ir (Month, L
cati	2 Accident Investigation 3 Suicide 6 Could not be 380 Place of		М	1 ☐ Yes 2 ☐ No							
rtil	4 Homicide determined 28e. Place of I building,	njury - At home, farm, s etc. <i>(Specify)</i>	street, factory, o	Office	28f. Location (Street a City or Town, Sta	and Number or H ite)	turai Houte Number,				
ပ္သ	29a. Certifier 1 Certifying Physician: To the be	et of my knowledge de	ath occurred a	t the time date and place	and due to the course	(e) and manner	as stated				
ica	(Check only 2 Medical Examiner: On the basis										

DHMH 17 Rev 1/2001

State Registrar

SCD

and manner state

gistrar's Signature

o completed gau

Signature and title of certifier

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 0830 COPELAND ELBOURN 2009 JUNE 26 AUL /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner CHESTERTOWN KEN HESTER

Social Security Number HOSPITAL CENTER RIVER Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday, Funeral Months Days Hours 1 **X**M 2 □ F 11/11/1939 69 MD Director 216-38-9694 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r 28a-f show notified at 1 ☐Yes 2X No Director KENT ROCK HALL MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or pe Items 23a cliner must be USA 21661 20873 ROCK HALL AVE filed within 72 hours after death the Hygiene. Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. armed Forces?

1 ☐ Yes 2X No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 'natural", or altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify. þ 3 □ Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other than 12 LUMBERJACK LUMBER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be partment of Health and Mental | ortant: If Item 27 is marked of Injury or other traumatic even permit. Pages 1 and 2 should be 1 Department of Health and Mental I Important: If Item 27 is marked o THOMAS BENNETT ELBOURN MABEL MCGINNIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ELINOR ELBOURN/WIFE 20873 ROCK HALL AVE ROCK HALL, MD 21661 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) ST. PAUL'S CEMETERY 6/30/09 CHESTERTOWN, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEER RD. CHESTERTOWN, MD 21620 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complicate his that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury a consequence of Examiner requires that the death certificate be executed that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) the 9□Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccourse contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Leun Completed 24a. Was an Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy perform 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3□ DOA 2 ER/Outpatient Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner eath 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? After 1 Matural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No s after death. death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a' Hospital 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one and manner stated. To the ! 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 360 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 Brown St. Chestertown, and 21620 Schoil MD Aman.

DHMH 17 HeV 1/2001

State Registrar

ms JUN 30 200

31. Date filed (Month, Day, Year)

ORIGINAL ORIGINAL

32. Registrar's Signature

		For State Registrar  1. Decedent's Name (First, Middle,		iviai yiaii		rtificate o		Re	g. No.2 0 0 9	2221	
Physicia /Medica	al		ARTHA JANE		ERS EVA	T	, or Location of Death	2. Date of Death Month	Day Year 4 209  4c. County of Dear	3. Time of Death	
Examine	er		E BOUNDAR'			4b. City, Town	CAMBRIDGE		1	CHESTER	
Funeral Director		213-14-7399	5. Sex 1 □ M 2 🕱 F	Age (In yrs. 85	last birthday) Yrs.	If Under 1 Yea Months Day		8. Date of Birth (Month, Day, 11/20/	Yea <i>r</i> ) 9. Bir 1923 9. Bir	thplace (State or Fore ountry) MARYLAND	
filed within 72 hours after death with the Maryland Hygiene. Ther than "natural", or items 23a or 28a-f show ent, the Mydical Ever, incr., ust be notified at	Director	Usual Residence of Decedent  10a. State 10b. County  MARYLAND DOR  10e. Street and Number	CHESTER	10c. Cit	y, Town or Lo	cation 10f. Zip Code	CAMBRIDGE	1.10	of What Co	10d. Inside City Lim 1 X Yes 2 □ I	
items 23a or			E BOUNDAR				21613		10g. Citizen of What Country?  USA		
"natural", or items	d by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Marrie  3 ☑ Widowed 4 ☐ Divorced	d 12. Was Decede Armed Force 1 ☐ Yes 2 If Yes, Give Year or Date	es? ▼No		Was Decedent o If Yes, specify Co 1 □Yes 2🛛 N	f Hispanic Origin? (Specuban, Mexican, Puerto For Specify:	cify Yes or No- lican, etc.)	14. Race - Ame Black, White Specify:		
d within 72 h giene. ar than "natu the Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12	Education grade completed) College (1-4d	or 5+)	16a. Dece (Give life, I		supation le during most of working red) SECRETARY	9	6b. Kind of Business/	Industry EGAL	
t of Health and Mercal High friem 27 is marked other or other traumatic event, tr	To Be C	17. Father's Name (First, Middle, La	RA DAIL SAN	NDERS			18. Mother's Name		laiden Surname) E BROMWEL	L	
ealth and Mental n 27 is marked o		19a. Informant's Name/Relationship JAMES STEPHE		)N	19b. Mailir		et and Number or Rural				
not of Hear int or other		20a. Method of Disposition  1   Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spe	□ Removal from Sta	20b. P	emetery, crer	sition (Name of matory or other p	lace) Da	ite 2	Oc. Location - City or		
Baltimore, permit. Pages 1 ar Department of Hea Important: if item? any Injury or other		21. Signature of Funeral Service Li	4	we o	22	2. Name and Add	'			,	
nysician 'Medical		23e- Fart LEnter the disease, or or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a. a.	sed the death line.	Atic	D	ying, such as cardiac or	respiratory arre	st,	Approximate Interval Between Onset and Death	
as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	bto (or	as a consequ	tence ci).			-			
or use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☐ No. 9 ☐ Unknown		23d. Date of delivery Month Day Ye							
g ge d	ব	Part II. Other significant condition	s contributing to death	h but not resu	ılting in the ur	nderlying cause ç	given in Part I.	23e. Did toba	acco use contribute to	the cause of death	
ate has b	Completed							24a. Was an autopsy perform	ed? prior to death?	itopsy findings availa completion of cause	
certifi	Be	25. Was case referred to medical examiner?	Hospital:				26. Place of Death				
within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Certification: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigal	28a. Date of I (Month, I		ER/Outpatien 28b. Time of Injury	28c. In.	4 LI Nursing Hom	<u> </u>	nce 6	cify)	
24 hours after d Funeral Direct tely filled in by t		3 ☐ Suicide 6 ☐ Could no determina	ed 28e. Place of building,	etc. (Specify	<i>'</i> )	eet, factory, office		City or Town,			
the Fune	Medical	one)	Physician: To the be caminer: On the basis and manner	s of examinal	wledge, death tion and/or in	vestigation, in m	time, date and place, a y opinion, death occurre	nd due to the ca d at the time, da	use(s) and manner as te and place, and due	s stated. to the cause(s)	
To the comple	_	29b. Signature and title of cegifier  29c. License number  29d. Date signed (Month, Day  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Michael Fyeld W 30 30 2 Cellins are Ifen fock Med 7164  31. Date filed (Month, Day, Year)  32. Registrar's Signature									
		Madelte	elilin.	101-4			000-		/		
State	9	30. Name and address of person when the last of the la	lden m		23a) (Type, lure	Collins	save 14	er lock	md 21	643	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month Day Physician THELMA LOTTIE EURE 28 2009 8:37 A June /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Salisbury Wicomico Nursing Home If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day) 9. Birthplace (State or Foreign Country) Social Security Number (In yrs. last birthday) **Funeral** 90 Days Hours 1 □ M 2 KF 213-44-0281 Director death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f shov Examiner must be notified at 28a-f show 1. Tes 2 □ No Wicomico HEBRON Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12831 Funeral Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 KNo Specify Specify. Completed by 3 Widowed 4 □ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1-OMEMAKER OWN HOME Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 3SEPH R. WANDING MANSEAU 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SANDRA MALONE (DAUGHTER) KD HEBRON, MD Baltimore, 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Surial 2 Cremation 3 Removal from State SPAINGHILL MEMORY GH'S 7-1-09 HEBRONIMD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Cyfern haxel 8 moo46 MESSICK FUNFINLHOME 10 SOX 23a. Part1. Enler the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MESSICK FUNIFIALHOME NO BOX 6 1 BIYALVE, MED 2 Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-trar attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death the 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 4 Unknown 1 TYes Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autonsy To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Matural 5 ☐ Pending investigation 1 🗌 Yes 2 Accident Funeral Director: 6 □ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier (Check only one) and manner stated. within 2

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

fuln

Maesha Thimmarayappa, MD

JUN 30

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

614 Easternshore Drive, Salisbury, MD 21804

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 5:38 p M 2009 EDWARD HENRY FREEMAN JUNE 26 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE"S BRADFORD OAKS NURSING HOME CLINTON If Under 1 Year Months Days Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 1 ★ M 2 □ F Hours Min. Columbus, NC Director 9/30/1914 245-12-1181 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County items 23a or 28a-f show iner must be notified at 1X Yes 2 No Funeral Director Maryland Prince George's Clinton 10g, Citizen of What Country? 10f. Zip Code 7520 Surratts Road <u>United States</u> Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 11. Marital Status 1 □ Never Married 2 □ Married If Yes, Give Year or Dates: 1 ☐Yes 2X No Specify: Specify: Black Completed by 3 ₩ Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Truck Driver Wholesale 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be traumatic ို Galvester Wesley Freeman Mary Dudley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dwayne Freeman / Grandson 329 17th Street NE Washington, D.C. 20002 item 2 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department of Important; If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 🕅 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 8, 2009 Lake Waccamaw, NC Cutler Cemetery 21. Signature of Funeral Service Licebsee 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 Par 1. Enter the disease, in complications that caused the death. Do not enter the mode of dyling, such as cardiac or respiratory arrest shock, over eart failure. List only one cause on each line. 23a. Pari 1. Immediate Cause (Final disease or condition resulting in death) **Physician** DEMENTIA /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last iner Due to (or as a consequence of): Exam and burial-trai Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 2 🗆 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tyes 2X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □ Yes 2 🔀 No 2 👿 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 👿 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 🙀 Natural 5 ☐ Pending investigation 1 Tyes after death. 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 24 hours a 29a. Certifier 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Hospital

within 2 To the I

Physician: The law requires that the death certificate be executed

Box 68760.

P.O.

Records,

of Vital

Division or Attending

Baltimore, Maryland 21215-0036

State Registrar (Check only one)

29b. Signature and title of certifier

William T. Tanner MD 11701 Livingston Road Fort Washington, Maryland 20744 31. Date filed (Month, Day, JUN 3 0 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

and manner stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

d35206

29c. License number

29d. Date signed (Month, Day, Year)

June 27, 2009

For State Registra Amend#20b.20c.PerFHPCC7-2-09cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Anthony С. June /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Cheverly Prince Georges Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F 577-80-4041 **Director** June Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Capitol Heights Director PG MD 10f. Zip Code 10e. Street and Number 20743 1117 Hybrid Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🏋 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or Ite 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕍 No If Yes, Give Š 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) None 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dorothy Isreal Foxx ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6104 Surrey Square Lane #101
District Heights, Md. 20747 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau once. Donita Foxx/sister 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lincoln Memorial Cem 20a. Method of Disposition 7/3/09 1 Burial 2 □ Cremation 3 □ Removal from State Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service License Part Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ۵ Completed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No 1 Inpatient 2X ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Natural 2 Accident 5 Pending within 24 hours after death. To the Funeral Director: A 1 ☐Yes 2 ☐ No investigation 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

Day Year 2009 5:18A 26, 4c. County of Death Prince Georges Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 13,1958 Wash., DC 10d. Inside City Limits 1 XYes 2 No 10g. Citizen of What Country? United States 14. Race - American Indian, Black, White, etc. Specify: Black 16b. Kind of Business/Industry None Datcher Suitland, 3910 Silver Hill Rd., Suitland, Md. 20746 Approximate Interval Between Onset and Death 23d. Date of delivery Year Month Day 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 ☐Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d, Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) CHEVERLY MD.

State Registrar 29b. Signature and title of certifier

DAVID 31. Date filed (Month, Day,

JUN 3 0 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

DRIVE

060096

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June 24, 2009 **Physician** 12:50 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9929 Woodburn Road Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Mar 21, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 X F 1913 Connecticut 96 046-10-9419 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Chevy Chase MD Montgomery death with the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20815 8100 Connecticut Ave. #920 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 💢 If Yes, Give Year or Dates: 2 **X**No 1 ☐ Never Married 2 ☐ Married 1∐Yes 2XNo 9 Specify: 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental F is marked otl William St John Mary Burns 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any injury or other trau Joan Flaherty/daughter 9929 Woodburn Road Silver Spring, MD 20901 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Final Journey Crematory 06/25/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service L Color Holles Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to or as a consequence of): Examiner reumenia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending about and attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be CAUGNTERS examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) nome 1 Yes 2 No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 ☐ Pending investigation 1 □Yes 2 □ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

ours after death.

leral Director: A
filled in by the fu

se of death (Item 23a) (Type, Print) Name and addr neal 31. Date filed (Mg nth, Day, Year) 32. Degistrar's Signature State JUN 26 2009 Registrar

29a. Certifier

(Check only one)

29b. Signature and tipe of certifier

Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Donald Freiert 4:50 p June 24,2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6909 Greenleigh Drive Howard Columbia 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours 1**⊠** M 2□ F 217-14-2636 Director 12/16/1922 NY 86 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or Items 23a or 28a-f show dical Examiner m<u>ust be notified at</u> 1 ☐ Yes 2 No Director MD Columbia Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21046 6909 Greenleigh Drive United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Department of Health and Mental Hygien Important: If Item 27 is marked other tha any injury or other traumant. American University Director of Payroll 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William K. Freiert Helen Agnes Young 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21044 6273 Audubon Drive Columbia, MD James Freiert - son altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Clarksville, MD 2009 Columbia Memorial 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Li > nsee 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. M00845 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ue to (or as a consequence of): **Physician** >1 Eacs /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner certificate be executed physician are the burial-t Due to (or as a consequence of): Box 68760 Physician/Medical aftending p for use as as IF FEMALE 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy in the past 12 months? Day 5 Other (specify) P.O. I signed by the a ☐Yes 2☐Yo 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy performed? page certificate 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No 27. Manner of Death Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient ၉ 2 ER/Outpatient 3 DOA 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division (Month, Day Year) 1 Natural 2 Accident 5 ☐ Pending investigation within 24 hours are: co...
To the Funeral Director: Aff 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital 29a. Certifier 🖏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

MALLAM

31. Date filed (Month, Day, Year)

**JUN 26** 

ise of death (Item 23a) (Type, Print)

MS

29c. License number

P20789.

11055 Little PATUXENT Colum

29d. Date signed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

_			1 - State Registrar		Ce	ertificate of l	Death		Reg. No.	10 22222
	Physici /Media		1. Decedent's Name (First, Middle, Last Mildred.	B. FRA	NZ			2. Date of Dea		ar 9-60 P M
and a	Examir		4a. Facility Name (If not institution, give Howard County Go		tal		r Location of Death		4c. County of D	
	Funeral Director		5. Social Security Number 6. Security Number 212-09-8481 Usual Residence of Decedent	x 7. Age (in	yrs. last birthday 93 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 6/21	h y, Year) /1916	Birthplace (State or Foreign Country)  MD
	filed within 72 hours after death with the Maryland Hygiene. wher than "natural", or items 23a or 28a-f show ant, the Widel Evening must be notified at	Director	10a. State 10b. County MD Howard	100	c. City, Town or L	ott City				10d. Inside City Limits 1 ☐ Yes 2 X No
	sath with this 23a or 2	Funeral Dire	10e. Street and Number  8501 Roberts Rd	12. Was Decedent Ever	i= 110	10f. Zip Code 210			United 9	·
9800	ours after d ral", or item Evominer	<u>و</u>	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	110.3.	. Was Decedent of H If Yes, specify Cuba 1 □Yes 2 No	Specify:	Rican, etc.)	Black, W	
21215-0036	be filed within 72 hours after death with the Marylan tial Hygiene.  do other than "natural", or items 23a or 28a-f show event, the Modical Everning roust be notified at	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Gecondary (0-12)	cation le completed) College (1-4or 5+)	(Giv	edent's Usual Occup e kind of work done o DO NOT use retired <b>Homem</b> a	during most of work d)	ing	16b. Kind of Busine	
Maryland 2	be od ev	To Be Co	17. Father's Name (First, Middle, Last)  Raymond Ellis					e (First, Middle,	Maiden Surname)	
ຜົ	and 2 tealth im 27 i		19a. Informant's Name/Relationship (7)  Larry Franz - S  20a. Method of Disposition	on	850:	1 Roberts	Rd. Ellic		er, City or Town, State  Ly, MD 210  20c. Location - City	)43
Baltimore,	permit. Pages 1 Department of P Important: If Ite any Injury or ot once.		1 Burial 2 Cremation 3 4 Donation 8 Other Specify, 21. Signature of June 1 Section 2.	ee	loodlawn	position (Name of ematory or other place Cemetery 22. Name and Address 4112 Old C	6/29, ss of Facility Hai	/09   cry H. V	Woodlaw Witzke's F	vn, MD Family F.H. In
The state of	Physician /Medical Examiner	er	23a. Part 1. Enter the disease, or comp shock, of heart failure. List only o Immediate Cause (Fin disease or condition resulting in death)  Sequentially list conditions,	ications that caused the ne cause on each line.  a	death. Do not en		ng, such as cardiac	or respiratory ar		Approximate Interval Between Onset and Death Pour Death
68760,	eath certificate be executed attending physician and for use as the burial-transit	Medical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	nsequence of):					
.O. Box 6	the death certifi y the attending ched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnanc:☐ Other (specify) _	у		23d, Date of Month	delivery Day Year
ords, P.	The law requires that the death ate has been signed by the atter bage 2 should be detached for u	2	Part II. Other significant conditions co	ntributing to death but no	t resulting in the	underlying cause give	en in Part I.	23e. Did to	. /	e to the cause of death?  Probably 4 Unknown
al Reco		Completed	OSTRO	HRTHRIT	713			24a. Was autop perfor 1 □ Yes	prior deat	e autopsy findings available to completion of cause of h? Yes 2 No
Division of Vital Records,	Attending Physician: It death, ector: After this certific by the funeral director,	on: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No  27. Manner of Death 1 ☑ Natural 5 ☐ Pending	1 Inpatient 28a. Date of Injury (Month, Day, Yea	2 ☐ ER/Outpation 28b. Time Injury		4 LI Nursing Ho	me 5 Resid	ne) dence 6 □ Other (S now injury occurred	Specify)
Divisio	755	Certification: To	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide	28e. Place of Injury - building, etc. (S		M 1 🗆	Yes 2□No	28f, Location (5 City or Tox	Street and Number o	r Rural Route Number,
	To the Hospital of within 24 hours at To the Funeral D completely filled in	edical	(Check only 2 Medical Exami	sician: To the best of my ner; On the basis of exa and manner stated.	mination and/or i	investigation, in my o	pinion, death occur	red at the time,	date and place, and	due to the cause(s)
	3.EG	2	30. Name and address of person who co	Ompleted source of de l'	(Hom COs) /T	29c Licens	30469		June  June	26, 200 9
,	Sta	io.	30. Name and address of person who con the control of the control	32. Registrar's S	Gignature	100 PAR	CKNAY, 4	308,	Collins	14 MD- 21045
	Sta Registr		JUN2 9 2			back				

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	•	1 - State Ce. Registrar Ce.	rtificate of Death	Reg. I		3. Time of Death
Physici	an	1. Decedent's Name (First, Middle, Last)			Day Vear	4:45 A M
/Medio		VICTORIA LOUISE SMITH FRIEDMAN			2009 4c. County of Death	4:45 A
Examin	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	'		
		107 CEDAR ST.	CHESTERTOWN If Under 1 Year I If Under 24 Hrs.	9 Date of Birth	KENT 9 Birtho	lace (State or Foreign
Funeral Director		5. Social Security Number  580-56-5907  6. Sex 1 M 2 M F  7. Age (In yrs. last birthday) 87 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Yes 10/12/192	Coun DOMIN	ICAN REP.
Hygiene.  Hygiene than "natural", or items 23a or 28a-f show ent, the Medical Examinar mant be rediffed at	_	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo			11	0d. Inside City Limits  Y Yes 2 No
Ba-f	5	MD KENT CHESTER		100	Citizen of What Coun	den 2
or 2	Dir	10e. Street and Number	10f. Zip Code 21620	"	JSA	u y :
233	ra	107 CEDAR ST.			14. Race - Americ	en Indian
Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show with injury or other traumatic event, the Medical Examinar mast be rediffied at once.	by Funeral Director	4 D November and ON Marriad 1 DVac 2 NO	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2X No Specify:	o Rican, etc.)	Black, White, e	etc.
"natural	Completed t	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of wor DO NOT use retired)		. Kind of Business/Ind	dustry
than	l di	Elementary/Secondary (0-12) College (1-4or 5+)	SICIAN	1	PUBLIC HEA	LTH
other ent,		17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid	den Surname)	
c ev	o Be	ALBERT WILLIAM SMITH	BLANCA	PUIG		
and in	욘		ing Address (Street and Number or Ru	ıral Route Number, Ci	ty or Town, State, Zip	Code)
27 is 27 is trau			OX 268 CHESTERTOWN			
tem (			osition (Name of ematory or other place)		. Location - City or To	wn, State
t: If I		1   Burial 2 M Cremation 3   Hemoval from State	i	( /00	meniencuti i	E MD
Important: If any Injury o		or City to at City and Compile Linears	KE CREAMTION: 6/2  22. Name and Address of Facility FELLOWS HELFENRE		<u>TEVENSVILI</u> M FUNERAL	
5 5 6 5		23a. Part 1. Enter the disease, or complications that caused the death. Do not en	FELLOWS, HELFENBER 130 SPEER RD. CHES	TERTOWN, I	MD 21620 _	Approximate Interval Between
of bhysician and set the burial-transit as the burial-transit	Il Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, it any, isating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	ondery Dis	il ase		
within 24 hous arist beau.  To the Funeral Director: After this certificate has been signed by the attending physi completely filled in by the funeral director, page 2 should be detached for use as the beautified in by the funeral director.	hysician/Medical	1	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deliv Month	Day Year
n signed Ild be de	d by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	1 ☐ Yes	co use contribute to t	ne cause of death? bably 4 ☐ Unknov
ite has bee age 2 shou	Completed			24a. Was an autopsy performed	prior to co	opsy findings availab impletion of cause o
tiffica tor, p	a	25. Was case referred to medical	26. Place of De	eth (Check only one)		
s cel	o O	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	Othor		e 6 ☐ Other (Speci	ify)
After this funeral of	F	7. Manner of Death Natural 5 □ Pending   2 □ Accident   Pending   2 □ Accident   Pending   2 □ Accident   New Year   28a. Date of Injury   28b. Time   Inju	of 28c. Injury at	28d. Describe how	injury occurred	
alter dea Director d in by the	Certification	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rur State)	ral Route Number,
Funeral Funeral	Medical C	29a. Certifier (Check only one)  1 CertifyIng Physician: To the best of my knowledge, dea content of the content of the pass of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occ	ce, and due to the cau curred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
within <b>To the</b> соттріє	Med	29b. Signature and title of Certifier	29c, License number		Date signed (Month,	
410	!	30. Name and address of person who completed cause of death (Item 23a) (Type	D005178	9 1	6/25/c	37
12		// )	() 1 211	1) [linani	mila 110	1000 OA

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** F. 6:15 BM Fisher Alice June 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examine Battimore

| If Under 24 Hrs. | University of Maghand Medical Contec 8. Date of Birth (Month, Day, Year)
Jan. 30, 1940 Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 □ M 2 1 F 219-36-6913 69 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the mydical Evacuture coust by natified at Director 1 XYes 2 No MD Dorchester Hurlock 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 72 hours after death with 111 Dorchester Avenue 21643 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Yes 2 If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🎦 No Specify. white 3 Midowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other two contracts. 12 Executive Secretary Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Earl W. Cole Pauline Milligan ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia L. Burton (Daughter) 2012 Hackberry Road Baltimore, MD 21221 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva June 26, 2009 Delmar, Delaware 21. Signature of Funeral Service Litensee 22. Name and Address of Facility
Short Funeral Home 13 East Grove Street 19940 Delmar, DE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final **Physician** MRSA Proumonia week disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Small cell lung cancer 2 Atrom 01 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Exami burial-tran Due to (or as a consequence of) attending physician Box 68760 Physician/Medical the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 No Month Year 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown ģ signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an has autopsy 1 □Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 2 Accident 5 Pending investigation Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the within 7 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) une 24,2009 Wacarr 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CECILY AGCADILI Baltimore MD Greene St. South 32. Registrar's Signature 31. Date filed (Month, Day, Year) State y Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-05042 State of Maryland / Department of Health and Mental Hygiene Charlie Henry Foskey 1- For State Certificate of Death Reg. No. Registrar Time of Death 2. Date of Death Physician/ 1. Decedent's Name (First, Middle,Last) June 26, 2009 0836 hrs Medical Examiner Charlie Henry Foskey 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Wicomico Salisbury 1601 South Division 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral oreign **Marryland** Months Days Hours Min 09/23/1934 Director 217-28-2577 1 X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Alle Yes 2 X No s 23a or 28a-f show e notified at once. Wicomico Salisbury Maryland 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 1601 South Division Street 21804 IISA Ö 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. lant: If item 27 is marked other than "natural", or items or other traumatic event, the Medical Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Never Married 2 X Married Specifywhite Yes 2 X No specify: If Yes, Give Year Widowed Divorced Korea ğ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Wicomico Elementary/Secondary (0-12) College (1-4 or 5+) more, MD 21215-0036
Pages 1 and 2 should be filed within 72 hent of Health and Mental Hygiene. Vault Company owner/founder 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nathan James Foskey Sally Mary Hill æ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barbara Jean Foskey/wife 1601 S. Division St., Salisbury, MD 21804 20c. Location - City or Town, State 20a, Method of Disposition 20b, Place of Disposition (Name of cemetery, Date Baltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State Salisbury Crematory 6/29/09 Salisbury, MD Donation 5 Other Specify 22 Holloway Funeral Home Professional Association aric CFSP 501 Snow Hill Rd., Salisbury, MD 21804 Docamora 23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death Contact Gunshot Wound of Head Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical physician a UNPENDED AMENDED To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760. 23d. Date of delivery 23c. If ves, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Dav Fetal death signed by the attending be detached for use as past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. ģ Yes 2 ✔ No 3 Probably 4 Unknown Completed Records, 24b. Were autopsy findings available 24a. Was an has been autopsy prior to completion of cause of death? performed? ✓ Yes 2 ✓ Yes 2 No page certificate 26.Place of Death (Check only one) Division of Vital 25. Was case referred to medical Be Other; examiner? Hospital: 1 Nursing Home 5 Residence 6 V Other: Scene ER/Outpatient 3 DOA Inpatient 2 this 1 Yes ٩ 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Certification: Subject shot self Jun 26, 2009 0825 hrs Natural Yes 2 V No Pending within 24 hours after death. Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 V Suicide Could not be or Town, State) 1601 South Division , Salisbury, MD determined (Specify) Single Family To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

Assistant Medical Examiner

32 Registrar's Signature

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

June 27, 2009

JUN 3 0 2009

30. Name and address of person who completed cause of death (Item 23a)

Patricia Aronica-Pollak MD.

31. Date filed (Mr

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Gerald Lee Griffin June 25. 2009 2:15 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Villa Rosa Nursing Home Mitchellville Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 □ F 078-30-8376 Director October 13, 1937 Canandaigua, NY Usual Residence of Decedent death with the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Show d other than "natural", or items 23a or 28a-f shovevent, the Medical Examirer must be notified at 1 X Yes 2 No Directo Maryland | Prince George's Hyattsville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 6305 Riggs Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian filed within 72 hours after 1 Never Married 2 Married XYes 2 Yes, Give 3altimore, Maryland 21215-0036 1 □Yes 2 🛛 No Specify 2 Specify: If Yes, Give Year or Dates: 1955–1959 White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Worker Contractor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be the Health and Mental John Leo Griffin Minnie Carnelia Trickey ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau Josephine Brasted / Friend 6013 Sarvis Avenue, Riverdale, MD 20737 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 Removal from State Maryland Veterans Cemetery 7/6/2009 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Dasch Janning Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Carcinomatosis Years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Mesothelioma, Pleural Years Sequentially list conditions, if or y leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐Yes 2 🗵 No 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed' 2 X No 1 ☐ Yes 2 □ No 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending death 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature 29d. Date signed (Month, Day, Year) 29c. License number title of certifie D32261 6/26/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5+1 Richard Jay Feldman, 9500 Annapolis Road, Suite # A4, Lanham, MD 20706 31. Date filed (Month, Day 32. Registra Signat State JUN 2 9 2009 Registrar

# ■ Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Physician Medical Examiner    Physician Medical Examiner   Legistrar   Legistr	Foreign TA Limits
Residence of Decedent   10s. State   10b. County   10c. City, Town or Location   10s. State   10b. County   10c. City, Town or Location   10s. State   10b. County   10c. City, Town or Location   10s. State   10b. County   10c. City, Town or Location   10s. State   10b. County   10c. City, Town or Location   10s. State   10b. County   10c. City, Town or Location   10s. State   10b. County   10c. City, Town or Location   10s. State   10b. County   10c. City, Town or Location   10s. State   10b. County   10c. City, Town or Location   10s. State   10b. County   10c. City, Town or Location   10s. State   10b. County   10c. City, Town or Location   10s. State   10b. County   10c. City, Town or Location   10s. State   10b. County   10c. City, Town or Location   10s. State   10b. County   10s. State   10b. County   10c. City, Town or Location   10s. State	Foreign TA Limits
Accounty of Death   Accounty of Death   Accounty of Death   BISHOPVILLE   WORCESTER	Foreign TA
10236 HAMMOND ROAD   BISHOPVILLE   WORCESTER	TA Limits
S. Social Security Number   6. Sex   128 M 2 F   7. Age (in yrs. last birthday)   FUnder 19ar   FUnder 24 Hrs.   8. Date of Birthday   9. Birthplace (State or Country)   100. City, Town or Location   100. Lists   100. City	TA Limits
Director    Solid	TA Limits
Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location  10d. Inside City  10d. Inside City  10d. State  10a. State  10b. County  10d. Inside City  10d. Inside City  10d. Inside City  10d. Inside City  10d. State  10d. Citizen of What Country?  10d. Inside City  10d. Inside City  10d. Inside City  10d. State  10d. Citizen of What Country?  10d. Inside City  10d.	Limits
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23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock or heart failure. List only one cause on each line.  Approximate Interval Betw	en
Physician  Immediate Ceuse (Final disease or condition	ath
/Medical resulting in death)  a. Due to (or as a consequence of):	45
Examiner	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  b. Due to (or as a consequence of):	
Due to (or as a consequence of):    The construction of the constr	
poetro a gentle underlying Cause (Disease of injury that initiated events resulting in death) Last  Cause (Disease of injury that initiated events resulting in death) Last  Due to (or as a consequence of):	
USE IF FEMALE:	
23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  23d. Date of delivery  1	ar
FFEMALE:   23c. If yes, outcome of pregnancy   23d. Date of delivery   1   Live birth 2   Fetal death   3   Ectopic pregnancy   23d. Date of delivery   Month   Day   Yes   1   Yes   2   No   9   Unknown   9   Unknown   Part II Other shortfloors contribute to the course of death   1   23c. If yes, outcome of pregnancy   23d. Date of delivery   Month   Day   Yes   23d. Date of delivery   1   Live birth 2   Fetal death   5   Other (specify)   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   9   Unknown   1   23c. If yes, outcome of pregnancy   23d. Date of delivery   Month   Day   Yes   23d. Date of delivery   1   Live birth 2   Fetal death   5   Other (specify)   9   Unknown   9   Unkno	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of de	ath?
The second secon	known
The second secon	
24a. Was an autopsy findings a prior to completion of ca performed?	ise of
performed? death? 1 yes 2 No 1 yes 2 No	
Use State of Death (Check only one)  25. Was case referred to medical examiner?  26. Place of Death (Check only one)  Hospital: 1 Inpatient 2   ER/Qutpatient 3   DOA   Other: 4   Nursing Home 5   Residence   State of Death (Check only one)	165
Pospital: 1 Inpatient 2 ER/Outpatient 3 DoA Other: 4 Nursing Home 5 Residence Other (Specify) From 27. Manner of Death  28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred	1E
27. Manner of Death 28a. Date of Injury 28b. Time of Injury Work? 1 Accident investigation 28b. Time of Injury M 1 Ves 2 No	
3 Suicide 6 Could not be determined determin	
Section   Sect	er.
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	Đ <i>r</i> ,
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	эг,
4 2 4 9 6 9 0 one) and manner stated.	
FEMALE:   23b. Was desceled pregnant in the past 12 months?   1   23c. If yes, outcome of pregnancy   1   23d. If yes 2   No 3   Ectopic pregnancy   1   23d. Date of delivery   Month Day You   1   23d. Date of delivery   Month Day You   23d. Date of delivery   23d. Date of delivery   Month Day You   23d. Date of delivery   23d. Date of de	
one) and manner stated.  29c. License number  29d. Date signed (Month, Day, Year)  Anstitu C. Uslandt M. A.  306241  06-26-09	
and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  29c. License number  29d. Date signed (Month, Day, Year)	
Aposthy C. Moleculate M. J. 06241 06-26-09  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

# Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,	spital or Attending Physician: The law requires that the death certificate be executed
₹	sicia
of	Phys
vision	spital or Attending
۵	spital or

Physician /Medical Examiner  4a. Facility Name (If not institution, give street and number)  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  15308 Bottle Run Road, NE  Cumberland  5. Social Security Number 6. Sex 216-50-0736 1 M 2 Z F 61 Yrs. Months Days Hours Min. Month, Day (Month, Day	ate or Foreign D ile City Limits Yes 2 █ No
Physician / Medical Examiner  Physician / Medical Examiner  1. Decedent's Name (First, Middle, Last)  Veronica Sue Greise  4a. Facility Name (If not institution, give street and number)  15308 Bottle Run Road, NE  Funeral Director  5. Social Security Number 6. Sex 1 Month Day Net Social Security Number 6. Sex 1 Month Day Net Social Security Number 6. Sex 1 Month Day Hours Min. O6/24/1948  7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Month Day Hours Min. O6/24/1948  9. Birthplace (Str. Country) Month Day Net Social Security Number 1 Month D	A44 M  ate or Foreign  D  le City Limits  Yes 2 No
Physician /Medical Examiner  Veronica Sue Greise  Greise  June 24, 2009  164  4a. Facility Name (If not institution, give street and number)  15308 Bottle Run Road, NE Cumberland  Allegany  Funeral Director  Sue Greise  Greise  4b. City, Town, or Location of Death  Cumberland  Allegany  7. Age (In yrs. last birthday) 1 Min. Month, Day, Year)  O6/24/1948  9. Birthplace (Str. Country) MIN. Months Days Hours Min. O6/24/1948  9. Birthplace (Str. Country) MIN. Months Days Hours Min. O6/24/1948	A44 M  ate or Foreign  D  le City Limits  Yes 2 No
4a. Facility Name (If not institution, give street and number)   4b. City, Town, or Location of Death   4c. County of Death	ate or Foreign  D  Le City Limits  Yes 2   No  No
Tuneral Director  15308 Bottle Run Road, NE  5. Social Security Number  216-50-0736  Usual Residence of Decedent  Cumberland  Cumberland  Allegany  7. Age (In yrs. last birthday)	Die City Limits Yes 2 No
Funeral Director  5. Social Security Number 216-50-0736  Usual Residence of Decedent  5. Social Security Number 1 M 2	Die City Limits Yes 2 No
Director   216-50-0736   61   975.   06/24/1948   MI   Usual Residence of Decedent	ie City Limits Yes 2 A No
	Yes 2 No
MD Allegany Cumberland    1	n,
10e. Street and Number  10e. Street and Number  10f. Zip Code  10g. Citizen of What Country?  15308 Bottle Run Road, NE  21502  11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired)  15. Decedent's Name (First, Middle, Last)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired)  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)  19b. Mailing Address (Street and Number or Bural Boute Number. City or Town State Zin Code)	
The property of the property o	
11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Education (Specify only highest grade completed) 16. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19. Mealthcare 19. Marital Status 1 Never Married 2 Namerical India Black, White, etc. 19. Specify: 10. Specify: 11. Marital Status 1 Never Married 2 Namerical India Black, White, etc. 11. Yes 2 No Specify: 12. Was Decedent to Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes, specify: 14. Race - American India Black, White, etc. 14. Race - American India Black, White, etc. 14. Race - American India Black, White, etc. 15. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16. Kind of Business/Industry 18. Mother's Name (First, Middle, Maiden Surname) 18. Mother's Name (First, Middle, Maiden Surname) 19. Mailing Address (Street and Number or Rural Boute Number. City or Town State Zin Code)	
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Company of the property of t	
Polity of the property of the	
Poscar Vernon Meeks  Reba Elizabeth (Scott) Meeks  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Bural Boute Number. City or Town State Zin Code)	
See E 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number. City or Town State Zin Code)	
Lawrence F. Greise/Husband 15308 Bottle Run, NE, Cumberland, MD 21502	
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State	э
4 Donation 5 Other (Specify) MD. Vet. Cem. 06/29/2009 Flintstone, MD	
21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Home	≥, PA
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or real atory arrest.  Approx.	mate
shock, or heart failure. List only one cause on sich line.  Chyclogon Immediate Cause (Final	Between and Death
/Medical disease or condition resulting in death) a. Due to (or as a consequence of):	mes-5
Examiner	
Sequentially list conditions, in any, leading to infinitediate Due to (or as a consequence of).  Cause. Enter Underlying Cause (Disease or injury	
S S L That initiated events C.	
p page   a   a   a	
q q privsi	
d.    FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2 No 3   Probably 4   Pregnant at time of death but not resulting in the underlying cause given in Part I.    Present of pound of the past 12 months?   1   Live birth 2   Fetal death   5   Other (specify)   Month   Day	
in the past 12 months?    Solution   Image: Solu	Year
1   Yes 2 MNo 9   Unknown 9   Unknown 9   Unknown 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause	of death?
1   Yes 2 Mo 3   Probably 4	
To plan of the series of the s	
e ge c ge c ge c ge c ge c ge c ge c ge	
1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   No   No   No   No   No   No	
examiner?  o	
27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred Work?	
The state of the s	
Second Content   Specify   Second Content   Sp	vumber,
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
25. Was case referred to medical examiner?    1	se(s)
	ir)
5 D22181 June 26, 2009	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Gary L. Wagoner, 925 Bishop Walsh Drive, Cumberland, MD 21502	

December   Security   Municipal   Charling   Security				For State Registrar	State of Ma			ırtment of H <i>tificate of L</i>		iental Hy	giene Reg. No	Z11114	22230
Charles  Cha					st)			<u>:-</u>			eath		3. Time of Death
Security Number of red nettinon, give a state and number)  Country House Residences  Country House Residences  Country House Residences  Country House Residences  Country House Residences  Social Security Number  Country House Residences  Social Security Number  Life Social Se				Charles	Edwa	ard		George				*	10:00 P M
Second Second Number   Content   The Content   Content	. A.			4a. Facility Name (If not institution, giv	re street and number)			4b. City, Town, or	Location of Death		4c.	County of Deat	
The control of the co	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,												, ,
Use   Head and processed   Control				214-05-6376	Ed to a Die								
Jesse Burton   George Bertha   Klavuhn   Stephen   Ste		pul \star				10c City Town	or Loc	cation					
Jesse Burton   George Bertha   Klavuhn   Stephen   Ste		faryla Fsho	o		anv	roc. Oity, rown							1 □Yes 2 ☑ No
Jesse Burton   George Bertha   Klavuhn   Stephen   Ste		the N 28a-	rect		,						10g. Cit	tizen of What Co	
Jesse Burton   George Bertha   Klavuhn   Stephen   Ste		3a or		17819 McMullen	Highway				21557		_	IISΔ	
Jesse Burton   George Bertha   Klavuhn   Stephen   Ste		death	ner		12. Was Decedent B	Ever in U.S.	13. V	Vas Decedent of Hi		ecify Yes or N	0-	14. Race - Ame	rican Indian,
Jesse Burton   George Bertha   Klavuhn   Stephen   Ste	036	urs after al", or ite	by		1 ☐ Yes 2 ☐ 1 if Yes, Give	10				nican, etc.)		Specify:	
Jesse Burton   George Bertha   Klavuhn   Stephen   Ste	2- 0-	72 ho	eted	15. Decedent's Ed	ducation	16a. [	Deced	lent's Usual Occupa	ation	ina	16b. K		
Jesse Burton   George Bertha   Klavuhn   Stephen   Ste	7	ithin he.	mple			+)			)	ing.			
Jesse Burton   George Bertha   Klavuhn   Stephen   Ste	2	Hygie Hygie ther ti		9 17 Fether's Name (First Middle Last	1		Со	-Founder	18 Mother's Name	(First Middle			cion Co.
20a. Method of Disposition 1 Date   20c. Location - City or Town, State   20b. Privacy commonly or development   Date   20c. Location - City or Town, State   20c. Location - City or To	an	be d c	$\mathbf{\omega}$	_		Ge	eor	ge			, maiden		ın
20a. Method of Disposition 1 Date   20c. Location - City or Town, State   20b. Privacy commonly or development   Date   20c. Location - City or Town, State   20c. Location - City or To	Z Z	shoul nd Me mark	ř	19a. Informant's Name/Relationship (	Type. Print)				and Number or Run	al Route Numi	per, City o	or Town, State, 2	Zip Code)
Display   Company   Comp		and 2 salth a		Pauline C. George	e / Wife	1'	781	9 McMulle	en Highwa	y, Ra	wline	gs, MD	21557
Physician Medical Examiner  Ph	ore o	of He			Removal from State	20b. Place of I	Dispos , crem	sition (Name of natory or other place	e) [	Date	20c. Lo	ocation - City or	Town, State
Physician Medical Examiner  Ph	Ē	Pag tment tant: jury c		4 □ Donation 5 □ Other (Specif	(y)	Hillor							
Physician Modical Exeminor    Physician Modical Exeminor   Security   Securit	Ra	permit Depar Impor any in once.		21. Fign wure of Funeral Service Utcer									
Physician Medical Examiner:  Examiner  Examiner  FremALE:  28. Was case referred to medical events are an object to make a consequence of):	H			23a. Part 1. Enter the disease, or com	lications that caused	the death. Do no	ot ente	er the mode of dyin	g, such as cardiac	or respiratory	arrest,		Interval Between
Due to (or as a consequence of):  Sequentially list conditions, sequence lists, leading to immediate causes, shift Underlying that intellisted events truly that intellisted events truly that intellisted events truly that intellisted events truly that intellisted events truly that intellisted events truly that intellisted events truly that intellisted events truly that intellisted events truly that intellisted events truly that intellisted events truly that intellisted events truly that intellisted events truly that intellisted events truly that intellisted events truly that intellisted events truly that intellisted events truly that intellisted events truly that intellisted events truly that intelligent events truly that intellisted events truly that intellisted events truly that intellisted events truly that intellisted events truly that intellisted events truly that intellisted events truly that intelligent events truly that intelligent events that in the past 12 months?    FEMALE: 23b. Was decadent pregnant in the past 12 months?   23c. If yes, outcome of pregnancy   23d. Date of delivery		Physician		Immediate Cause (Final disease or condition			>me	ntia				1	Onset and Death
Due to (or as a consequence of):    Subject   Construction   Const				resulting in death)									
The an initial death of the composition of the comp			ē	Sequentially list conditions, if any, leading to immediate	b	a consequence of	):						
FFEMALE: 23b. Was decedent pregnant in the past 12 months?   Coronary Artery Disease   Diabetes Mellitus Type 2   24a. Was an autopsy   Coronary Artery Disease   Diabetes Mellitus Type 2   25b. Was case referred to medical examiner?   Coronary Artery Disease   Diabetes Mellitus Type 2   25b. Was case referred to medical examiner?   Coronary Artery Disease   Diabetes Mellitus Type 2   25b. Was case referred to medical examiner?   Coronary Artery Disease   Diabetes Mellitus Type 2   25b. Was case referred to medical examiner?   Coronary Artery Disease   Diabetes Mellitus Type 2   25b. Was case referred to medical examiner?   Coronary Artery Disease   Diabetes Mellitus Type 2   25b. Was case referred to medical examiner?   Coronary Artery Disease   Diabetes Mellitus Type 2   25b. Was case referred to medical examiner?   Coronary Artery Disease   Diabetes Mellitus Type 2   25b. Was case referred to medical examiner?   Civo   Coronary Artery Disease   Diabetes Mellitus Type 2   25b. Was case referred to medical examiner?   Civo   Coronary Artery Disease   Diabetes Mellitus Type 2   25b. Was case referred to medical examiner?   Civo   Coronary Artery Disease   Diabetes Mellitus Type 2   25b. Was case referred to medical examiner?   Civo		cuted d ansit	min	Cause (Disease or injury									
FEMALE:   FEMALE:	ے ت	e exec		resulting in death) Last	Due to (or as	a consequence of	):	**					
FEMALE:   FEMALE:	α Ω	ate b	Jical		d								
June 28, 2009  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Gregg C. Donaldson, M.D., 912 Seton Drive, Cumberland, MD 21502  State 31. Date filed (Month, Day, Year)  A32. Registrar's Signature	ف ×	ding page as	Mec	IF FEMALE:	23c If was outcome	of pregnancy							
June 28, 2009  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Gregg C. Donaldson, M.D., 912 Seton Drive, Cumberland, MD 21502  State 31. Date filed (Month, Day, Year)  A32. Registrar's Signature	o n	atten for us	cian	in the past 12 months?	1 Live birth	2 Fetal death	3 [ 5 [	Ectopic pregnancy	1		İ		
June 28, 2009  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Gregg C. Donaldson, M.D., 912 Seton Drive, Cumberland, MD 21502  State 31. Date filed (Month, Day, Year)  A32. Registrar's Signature	ć.	t the c by the achec	hysi										
June 28, 2009  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Gregg C. Donaldson, M.D., 912 Seton Drive, Cumberland, MD 21502  State 31. Date filed (Month, Day, Year)  A32. Registrar's Signature	Š,	es tha igned be det	by P			ut not resulting in t	the un	nderlying cause give	en in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
June 28, 2009  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Gregg C. Donaldson, M.D., 912 Seton Drive, Cumberland, MD 21502  State 31. Date filed (Month, Day, Year)  A32. Registrar's Signature	<u>0</u>	equin sen si ould b	ted	Coronary Artery	Disease					1 🗆	Yes 2	MNo 3□ Pr	obably 4 Unknown
June 28, 2009  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Gregg C. Donaldson, M.D., 912 Seton Drive, Cumberland, MD 21502  State 31. Date filed (Month, Day, Year)  A32. Registrar's Signature	Š	has b	nple	Diabetes Melli	tus Type 2					auto	psy	prior to o	topsy findings available completion of cause of
June 28, 2009  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Gregg C. Donaldson, M.D., 912 Seton Drive, Cumberland, MD 21502  State 31. Date filed (Month, Day, Year)  A32. Registrar's Signature	<u>_</u>	n: Th ficate r, pag								1 □ Yes	2 XNC	1 ☐Yes	2 🗆 No
June 28, 2009  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Gregg C. Donaldson, M.D., 912 Seton Drive, Cumberland, MD 21502  State 31. Date filed (Month, Day, Year)  A32. Registrar's Signature	5	siclar certi recto		examiner?	Hospital:			Othe				- M ou	Assisted
June 28, 2009  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Gregg C. Donaldson, M.D., 912 Seton Drive, Cumberland, MD 21502  State 31. Date filed (Month, Day, Year)  A32. Registrar's Signature	0	g Phy er this eral d	Ë	27. Manner of Death	28a. Date of Inju	ry 28b. Ti	me of	28c. Injury	/ at	28d. Describe	how inju	ry occurred	city) Living
June 28, 2009  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Gregg C. Donaldson, M.D., 912 Seton Drive, Cumberland, MD 21502  State 31. Date filed (Month, Day, Year)  A32. Registrar's Signature	<u> </u>	ath. r: Aft	atio			<i>y, Year)</i> Inj	ury						
June 28, 2009  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Gregg C. Donaldson, M.D., 912 Seton Drive, Cumberland, MD 21502  State 31. Date filed (Month, Day, Year)  A32. Registrar's Signature	<u> </u>	r Atte	ţii l	- determine d	28e. Place of Inju	iry - At home, farr c. (Specify)	n, stre	eet, factory, office		28f. Location City or To	(Street ar	nd Number or Ru e)	ural Route Number,
June 28, 2009  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Gregg C. Donaldson, M.D., 912 Seton Drive, Cumberland, MD 21502  State 31. Date filed (Month, Day, Year)  A32. Registrar's Signature	2	urs af urs af eral Di		20-0-0-0									
June 28, 2009  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Gregg C. Donaldson, M.D., 912 Seton Drive, Cumberland, MD 21502  State 31. Date filed (Month, Day, Year)  A32. Registrar's Signature		he Hosi in 24 ho he Fune pletely f	edica	(Check only 2 Medical Exar	miner: On the basis of	f examination and	death or inv	vestigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time	e cause(s , date an	d place, and due	s stated. to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Gregg C. Donaldson, M.D., 912 Seton Drive, Cumberland, MD 21502  State 31. Date filed (Month, Day, Year)  /32. Registrar's Signature		To the within to the complete	Ž	29b. Signature and title of certifier				29c. License	number		29d. Da		
30. Nafine and address of person who completed cause of death (Item 23a) (Type, Print)  Gregg C. Donaldson, M.D., 912 Seton Drive, Cumberland, MD 21502  31. Date filed (Month, Day, Year)  A22. Registrar's Signature		10		1) Jal	10				2054			June 28	, 2009
State 31. Date filed (Month, Day, Year) /32. Registrar's Signature									rive, Cu	mberlar	nd, M	1D 2150	2
Registrar JUN JU 2009 / Land J. Daniel				31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	er#	W					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** DONALD STEVEN GERTZ 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** aston Memoria 8. Date of Birth (Month, Day, JAN. 9, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1956 **Funeral** 1 X M 2 □ F Months Days Hours Min. MARYLAND 53 Director 220-66-3332 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be rediffed at once. 1XYes 2 □ No Director MARYLAND QUEEN ANNE'S **QUEENSTOWN** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 109 TUEL LANE 21658 UNITED STATES Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married land 21215-0036 1 ☐ Yes 2X No Specify: WHITE Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CARPENTER CONSTRUCTION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ALBERT HOWARD GERTZ, JR. PATRICIA ANTHONY ပ timore, Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 109 TUEL LANE, QUEENSTOWN, MD 21658 PATRICIA A. GERTZ/MOTHER 20b. Place of Disposition (Name of CHESAPY ACTION CENTER CREMATION CENTER 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Pungral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final Physician disease or condition resulting in death) ulmonary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any lating to a madelly cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-trar attending physician and for use as the burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? has the funeral director, page 2 autopsy performed? 1 □ Yes 2 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28b. Time of Injury Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident To the Hospital or Attendential 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) Washington St, Easton, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 MD Dennett strar's Signature

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

		Pleas	se Type or F						=		gible.	
		For State Registrar	State of	Marylan	-		of Health a <i>of Death</i>	nd Me		ene J. No. 2	009	3 22232
Physicia		1. Decedent's Name (First, Middle, Mary I. Gayer	Last)			·			2. Date of Death Month June 24	Day 200	Year 9	3. Time of Death  12:13 a M
/Medica	er	4a. Facility Name (If not institution, Gilchrist Hosp		nber)		To	vn, or Location of	Death		4c. Cou Bal	nty of Deatl	e
Funeral Director		5. Social Security Number 213-44-3006  Usual Residence of Decedent	6. Sex 1 □ M 2 🔀 F	7. Age ( <i>In yrs. I</i>	ast birthday) Yrs.	If Under 1 Y	ear If Under 2 ays Hours	Min.	8. Date of Birth (Month, Day, 2/15/194	Year) 13	Co	hplace (State or Foreign untry) MD
e Maryland 8a-f show	Director	10a. State 10b. County  MD Howar	rd		y, Town or Lo	City						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Funeral Dire	10e. Street and Number  9301 Millbrook  11. Marital Status		dent Ever in U.	S. 13.	Was Deceden	ode 1042 t of Hispanic Orig Cuban, Mexican,	gin? (Spec	cify Yes or No-	Unit	of What Cor ed Sta Race - Ame Black, White	ates rican Indian,
hours after atural", or ite	ক্র	1 ☐ Never Married  3 ☐ Widowed 4 ☐ Divorced  15. Decedent's	ed 1 □Yes If Yes, Giv Year or Da	2√ No e No	16a. Dece	1 □Yes 🍇	No Specify:		11	Spe		hite
led within 72 lygiene. her than "na nt, the Media	Completed	(Specify only highest Elementary/Secondary (0-12)  12  17. Father's Name (First, Middle, L	college (1-	-4or 5+)	life.	kind of work of DO NOT use i perviso	or		g (First, Middle, Ma		tail	
should be fi and Mental H marked ot umatic ever	To Be	Stanley L. Amo	ss Sr.		19b. Maili	ng Address (S		a I	Snowden	Amos	s	Zip Code)
t. Pages 1 and 2 rment of Health a rtant: If item 27 is ijury or other tra		Stanley J. Gaye  20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other Sp  21. Signature of Furferal Service	3 ☐ Removal from Secify)	State 20b. P	lace of Dispo emetery, crei	osition (Name matory or othe wn Ceme	1	6/30	/09 M	oc. Locătio Iarrio	on - City or	Town, State
Physician /Medical Examiner		23a. Part 1. Enter the disease, or o shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)	complications that cannot one cause on ea	aused the death ach line.	h. Do not en	ter the mode of	Columb of dying, such as o	ia P	ike Elli r respiratory arre	cott		mily F.H.Inc , MD 21043 Approximate Interval Between Onset and Death
icate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	or as a consequ								
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown		oirth 2 🗖 Feta nant at time of c	I death 3	□ Ectopic prec □ Other <i>(spe</i> c				23d.	Date of de Month	livery Day Year
w requires that been signed b should be deta	þ	Part II. Other significant conditio	ns contributing to de	eath but not res	ulting in the u	inderlying caus	se given in Part I.		23e. Did tob		_	o the cause of death?
sician: The law recertificate has be	Completed									ed2 No	prior to death?	utopsy findings available completion of cause of
ding Physician: h. After this certifics funeral director,	on: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending	28a. Date	npatient 2  of Injury th, Day, Year)	ER/Outpatie	of 28c	Other: 4 Nu Injury at Work?	rsing Hor	me 5 ☐ Reside	nce 6 🗹		point vspice
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification: To	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ot be 28e. Place	of Injury - At ho ng, etc. <i>(Specit</i>	ome, farm, st	reet, factory, o	1 □ Yes 2 □ N		28f. Location (Str City or Town	eet and N State)	umber or R	ural Route Number,
the Hospit iin 24 hour the Funera	Medical (	(Check only 2 Medical I	g Physician: To the Examiner: On the b and mani			nvestigation, Ir	n my opinion, dea		ed at the time, da	ite and pla	ice, and du	e to the cause(s)
No it	2	29b. Signature and title of certifier	my Kr	ly.	uno		icense number	25				2009 2009
Una-		30. Name and address of person of the state	1 GB			Mr. C	limbe	St	. Bal	to.	ind	2050%
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Edmond J. Golden, Jr. June 20 2009 10:50 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 05/21/1957 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 212-76-5120 52 Alabama Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 □ Yes 2 No Director Maryland | Anne Arundel Harwood 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4463 Solomons Island Road 20776 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 █ No Specify: White Specify: ð 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any Injury or other traumatic event, fire Medic once. Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edmond J. Golden, Sr. Irene C. Cullen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Janice A. Golden/Wife 4463 Solomons Island Road, Harwood, Maryland 20776 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kalas Crematory 20c. Location - City or Town, State 06/21/2009 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part1. Enter the decase, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIC SHOCK **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events and the burial-trai resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) the 1 ☐ Yes 2 ☐ No 9 Unknown been signed by should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Ş</u> METASTATIC COLON CANCER 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe page 2 2 🗆 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 ∭TNo 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 1 XNatural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No ours after death. neral Director: A filled in by the fu investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital or within 24 hours af To the Funeral D 1 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D00058297 06/20/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard Young, Anne Arundel Medical Center, Annapolis, Maryland 21401 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

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			Registrar  1. Decedent's Name (First, Midd)	le. Last)		Ochinica	ie oi L		2. Date of D	Reg. No	o.	3. Time of Death
	Physici		Laura Avice Ga	,					Month 6	/20/	2009 Year	410am M
	/Medic Examir		4a. Facility Name (If not institution		mber)	4b. City	, Town, or	Location of De			. County of Death	
4			Mandrin Hospic  5. Social Security Number	e House	7 4 //	tri- 1 If I Inde	Ha er 1 Year	rwood	ro   0 D-1		Anne Aru	ndel
	Funeral Director		226-60-7702	1 □ M 2 H F	7. Age (In yrs. last birt	rs. Months	1	Hours Mi		1945	) Got	inflace (State of Poreign intry) MO
	and w		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town	or Location						10d. Inside City Limits
	Maryl -f sho	ξ	MD Anr	e Arundel		Annapol:	is					1 □Yes 2 No
	r 28a	Director	10e. Street and Number				ip Code			10g. C	itizen of What Cou	untry?
	h with	a D	1631 Foolish P1	easure Ct	•			2140	)9		USA	
	ems	Funeral	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U.S.	13. Was Dece	edent of His	spanic Origin?	(Specify Yes or Nerto Rican, etc.)	10-	14. Race - Amer Black, White	
36	s after , or it	by FL	1 ★ Never Married 2 Mar	ried 1 ∐Yes If Yes, Gi	2 <b>/Ti</b> No ve	1 □Yes		Specify:	or to rindari, otor,			√hite
21215-0036	hours tural"		3 Widowed 4 Divorced			Decedent's Usi	uoi Ooguna	tion		16h 1		ndi i ota i
15	in 72	plete	(Specify only highe	t's Education st grade completed)		Give kind of will life. DO NOT i	ork done di	urina most of w	orking	160. 8	Kind of Business/I	naustry
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pu	be filed within 72 hours after death with the Maryland tial Hygiene. id other than "natural", or items 23a or 28a-f show event, the the didner and the ricitlised at	BeC	17. Father's Name (First, Middle,	Last)				18. Mother's N	ame (First, Midd	e, Maide	n Surname)	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the medical Exercitive in ust be recitived.	၉	Clayton R. Garv	rey				Lila J	. Robert	ts		
Mar	2 shot and is m		19a. Informant's Name/Relations	hip (Type. Print)	19b.	Mailing Addres	s (Street a	nd Number or	Rural Route Num	ber, City	or Town, State, Z	ip Code)
e, Z	l and fealth em 27 ther t		Bonnie Pifer	Friend					Annapol:	<del></del>	1D 21409	01-1-
آور	nt of h		20a. Method of Disposition  ★□ Burial 2 □ Cremation		State	Disposition (Na v, crematory or		: 1//	3/2009	'	ocation - City or T	
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Ba	Depi any once	. 13	17 7 Ch	Licensee		12 Di.	doo lar	Ave	rdesty l Annapol:	Funer	cal Home	, P.A.
			23a. Part 1. Enter the disease, or	complications that c	aused the death. Do n						11) 21401	Approximate
	Physician	ř A	shock, or heart failure. List Immediate Cause (Final	only one cause on e	ach line.	4t.	1					Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a Due to	or as a consequence of	o con	_(.	me				
0.7	Examiner		Sequentially list conditions,	b	non If	ode	Ru	Ly	whe	w	9	
	pe #s	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	or as a consequence o	f):		7	7			
	xecuted and al-transit	xaminer	that initiated events resulting in death) Last	c	or as a consequence o	f):						
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68760	ficate be of physicians the buring	edic		d								
Box	eath certific attending p for use as t	N/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregnancy						23d. Date of deli	verv
	Attending Physician: The law requires that the death certificate be rideath. rector: After this certificate has been signed by the attending physicial by the funeral director, page 2 should be detached for use as the bur	by Physician/Medical	in the past 12 months? 1 □Yes 2 ☑ No		oirth 2 Fetal death	3 ☐ Ectopic 5 ☐ Other (s					Month	Day Year
P.0	that the de ned by the detached	Phys	9 ☐ Unknown									
S,	ires tha signed I be del	by	Part II. Other significant condition	ons contributing to de	eath but not resulting in	the underlying	cause give	n in Part I.				the cause of death?
9	w require been si should I	Completed	-						-   1	Yes 2		babiy 4 ☐ Unknown
ခိုင	elaw hasl	m M							24a. Wa	s an opsy formed?	24b. Were aut	opsy findings available ompletion of cause of
Vital Records,	ician: The certificate ha		05.11						1 □Yes	2 🗷 N	death? o 1 ☐ Yes	2 □No
Ξ	lysicia ils certi directo	Be C	25. Was case referred to medica examiner?  1 ☐ Yes 2 ☐ No	Hospital:	npatient 2 ☐ ER/Out	nationt 200	Other		eath (Check only			Hospice
of	g Phy er this eral o	Ë.	27. Manner of Death	28a. Date	of Injury 28b. T		28c. Injury Work?	4 LI Nuising	28d. Describe			my) Hospice
<u>.</u>	ttending F death. stor: After the funera	atio	1 ☑Natural 5 ☐ Pendin 2 ☐ Accident investi	9 1 .	th, Day, Year) In	jury M		r es 2 □No				
Division	r Atte	Certification: To	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	not be ined 28e. Place buildi	of Injury - At home, faring, etc. (Specify)	m, street, factor	y, office	375	28f. Location	(Street a	nd Number or Ru	ral Route Number,
	Hospital or 24 hours afte Funeral Dir tely filled in	Ce							W.			
	Hosp 24 hou Fune stely fi	Medical	29a. Certifier 1 Certifyir (Check only one) 2 Medical	Examiner: On the b	best of my knowledge, asis of examination and	death occurred or investigation	d at the tim n, in my op	e, date and pla inion, death oc	ace, and due to the curred at the time	e cause( e, date ar	s) and manner as nd place, and due	stated. to the cause(s)
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Mec	29b. Signature and title of certifie		ner stated.	29	c. License	number		29d. D:	ate signed (Month	, Day, Year)
	EC1)		Cint	- 1/	11.	100		330	6	1	1001.	0
			30. Name and address of person	who completed caus	e of death (Item 23a) (	Type, Print)	57	110		0	122/0	
	0		Curps Harr	s. MO	900 Be	575976	PRO	1 876	2300 1	Ann	apolic	MD 2149
	Sta		31. Date filed (Month, Day, Year)	32. P	egistrar's Signature	1 .	,				1007	
	Registr	ar	JUN 28	2009	neve B.	gare						

# Baltimore Maryland 21215-0036

Division of Vital Records. P.O. Box 68760.

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Physic	ian	1. Decedent's Nam	e (First, Middi	le, Last)	GIL	119					2. Date of De	eath Day	Year	3. Time of Death	
/Med Exami		4a. Facility Name (	, ,, ,	n, give street				4b. City, Town, o	r Location	of Death	06	23 4c.	2009 County of Deat		
<i>!</i>		UNIVERSITY	of MAR	YLAND	MEDICA		TER	BALT IA	TORE	r 24 Hrs.	8. Date of Birth 9. Birthplace (State or Foreign				
Funera Director		5. Social Security N 578 72		6. Sex		ge <i>(In yrs. la</i> 55		Months Days	Hours	Min.	8. Date of Bir (Month, Da 06/04/	ay, Year)	Co	shington DC	
and		Usual Residence of	f Decedent 10b. County			10c, City	, Town or Lo	cation						10d. Inside City Limits	
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with the	I Director	10e. Street and Nut		l Oak	Driv	<i>r</i> e		10f. Zip Code 20	501			10g. Citiz	z <i>e</i> n of What Co ▲	untry?	
death	Funeral	11. Marital Status		Α.	as Decedent		3. 13.	Was Decedent of H		rigin? (Sp	ecify Yes or No		14. Race - Ame Black, White		
and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. It has the marked other than "natural", or items 23a or 28a-f show other traumatic event, the Marical Examinant or items 1	þ	1 Never Marr 3 □ Widowed		ried 1	∏Yes 2 ☐ Yes, Give ear or Dates:	<b>N</b> o		1 □Yes 2 <b>X</b> No			ruodin, otoly			Black	
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be file tal Hy dothe event,	Be	17. Father's Name		ŕ					18. Mother's Name (First, Middle, Maiden Surname)  Betty Ann Hughes						
should be the Mental marked o	2	Joseph					19b. Mailir	ng Address (Street					gnes or, City or Town, State, Zip Code)		
es 1 and 2 a		Joseph	S. Gi	llis,	Sr.			Counci	1 Qa					20601	
permit. Pages 1 and 2 Department of Health 8 Important: If item 27 is any injury or other tra		20a. Method of Dis 1 Burial 2	Cremation		al from State	20b. Pla Riv	erdal	sition (Name of matory or other pla e Park	ce)		Date		cation - City or		
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hysicla his cer	To Be	examiner?		Hospit	al: 1 🔀 Inpati	ient 2 🗆 8	ER/Outpatle	nt 3 DOA Oth					6 □Other (Spe	ecify)	
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or Attending Physician: The law requires that the death certificate after death.  Director: After this certificate has been signed by the attending phys in by the funeral director, page 2 should be detached for use as the	Certification:	3 Suicide 4 Homicide	6 Could detern	not be	e. Place of In building, e	jury - At hor tc. (Specify	me, farm, str	eet, factory, office			28f. Location City or To	(Street an wn, State	d Number or R )	ural Route Number,	
To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fun		29a. Certifier (Check only		Examiner: (	On the basis	of examinat		h occurred at the t							
To the within 2 To the complete	Medical	29b. Signature and	title of certific	-	THOMA		IARIA, M	29c. Licens					te signed (Mon	th, Day, Year)	
		30. Name and add	ress of person	who comple				1141			8974		6/20/	2009	
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St Regis	tate trar	31. Date filed (Mon	JUN 26	2009	32. Regist	rar's Signati	9. So	wed							

	For State	State of Ma	ryland / I	Mental Hy	I Copies Are Legible.  lental Hygiene														
	Registrar			Certif	ficate of	Death	1001 (0	Reg. No.2	3 2223										
an	1. Decedent's Name (First, Middle,	Last)					Date of De     Month	Day Yea											
al	DANI		LEE		TARU	IN	JUNE												
C1	4a. Facility Name (If not institution,					r Location of Dea		4c. County of De	_										
	CHESTER RIUS 5. Social Security Number	8. Date of Bir (Month, Da	th 9. E	irthplace (State or Fore															
	284-54-1304	5. Sex 7. Age 1 2	Hours Min	. (Month, Da	av. Year)	OH OH													
-	Usual Residence of Decedent																		
	10a. State 10b. County		10c. City, Tow		on				10d. Inside City Limi										
Director		ANNE'S	MAR	YDEL	101 7: 0.1.			10g. Citizen of What											
5	10e. Street and Number 810 EVERETT RD				10f. Zip Code 21649	1		USA	Courity?										
5		12. Was Decedent E	verinIIS	13 Was			Specify Ves or No												
runerai	<ol> <li>Marital Status</li> <li>Never Married 2</li></ol>	Armed Forces?					Specify Yes or No rto Rican, etc.)	Black, Wi											
2	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1982	1 🗆	Yes 2X No	Specify:		Specify:	WHITE										
De la	15. Decedent's (Specify only highest		16a	. Deceden	t's Usual Occup	nation during most of we	arkina	16b. Kind of Busines	ss/Industry										
Completed	Elementary/Secondary (0-12)	College (1-4or 5-	) MD	`life. DO	NOT use retire	SOURCE P	•	TAIL ENEO	OCEMENT										
3 -	12		1110					LAW ENFO	KCEMEN I										
ă	17. Father's Name (First, Middle, La							, Maiden Surname)											
2 -	DARWIN D. GARV	··-·	100				J. TOWN		- T - O - (1)										
	19a. Informant's Name/Relationshi GERALDINE GARVI			-			DEL, MD	рөг, City or Town, State 21640	e, Zip Code)										
ŀ	20a. Method of Disposition	N- WIFE	20b. Place o	of Disposition	on (Name of		Date Pin	20c. Location - City	or Town, State										
	1 X Burial 2 ☐ Cremation 3		cemete	ery, cremate	ory`or other pla	1	2 / 2000												
ŀ	4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Li		ST. D				3/2009	GALENA, M											
	21. Signature of Furieral Service Li							NAM FUNERA											
7	370 W. CYPRESS ST. MILLINGTON, MD 21651 23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,																		
	Interior Consecutive Cause (Final Consecutive Cause on each line.																		
Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):																			
<u> </u>																			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):																			
3																			
NA C	IF FEMALE:	23d. Date of	delivery																
Physician/Medica	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 3			ctopic pregnand ther <i>(specify)</i> _	y		Month	Day Year										
ly S	1 □ Yes 2 □ No 9 □ Unknown	9 🗆 Unknown			(, ),														
Z	Part II. Other significant condition							tobacco use contribute	to the cause of death?										
2	McMs cultin	21212 M	<u>ر</u> حر	tap	4/100	secus	1 🗆	Yes 2□No 3□	Probably 4 Unknown										
	Aureus						24a. Was		autopsy findings availa										
nalaid							ormed?   death												
nandino		performed?   death? 1 □ Yes 2 □ No 1 □ Yes 2																	
-	25. Was case referred to medical		25. Was case referred to medical examiner?																
מ		Hospital: Inpatier	nt 2 ☐ ER/O	utpatient	3 □ DOA Oth	or:													
ב	examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death	Inpatiei		utpatient Time of Injury	3 LI DOA	er: 4 🗆 Nursing	Home 5 ☐ Res		pecify)										
De	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investiga	28a. Date of Injur (Month, Day		Time of	28c. Inju	er: 4 🗆 Nursing	Home 5 ☐ Res	idence 6 □Other (S	pecify)										
De	examiner? 1 Yes 2 No  27. Manner of Death Natural 5 Pending	28a. Date of Injur (Month, Day	y 28b.	Time of Injury	28c. Inju	er: 4  Nursing ry at k?	Home 5 ☐ Res 28d. Describe	idence 6 □Other (S											
Certification: 10 be	examiner?  1 Yes 2 No  27. Manner of Death Natural 5 Pending investiga 3 Suicide 6 Could no 4 Homicide determin	28a. Date of Injur ution of be thed 28e. Place of Injur building, etc	y 28b. (Year) 28b. ry - At home, fa	Time of Injury	28c. Injur Wor M 1 [	er: 4 □ Nursing y at k? Yes 2 □ No	Home 5 Res 28d. Describe 28f. Location ( City or To	idence 6 □Other (S how injury occurred (Street and Number or wn, State)	Rural Route Number,										
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legical Certification; To Be	examiner?  1 Yes 2 No  27. Manner of Death	28a. Date of Injur (Month, Day) at be led 28e. Place of Injur building, etc  Physician: To the best of xaminer: On the basis of and manner sta	y 28b.  ry - At home, factoristics (Specify)  of my knowledge examination a	Time of Injury  arm, street,	28c. Injumer Wor 1 Control of the total of t	er: 4 Nursing  y at  k?  Yes 2 No  me, date and pla  popinion, death occors  enumber	And the second of the second o	idence 6 Other (S how injury occurred  (Street and Number or wn, State) e cause(s) and manne, date and place, and c  29d. Date signed (Mo	Rural Route Number,  as stated. tue to the cause(s)  onth, Day, Year)										
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		For		State of	f Marylan	nd / Dep	artmen	t of He	ealth a	and M	lental Hy	giene			
	•	1 - State Registrar				Ce	ertificat	e of D	eath			Reg. No.	009	2223	İ
Dharis		1. Decedent's Name	e (First, Middle, I	Last)							2. Date of De	eath Day	Year	3. Time of Deat	th
Physici /Medio		Elmer W	infred G	aile							June	25,	2009	6:00 A	M
Examir		4a. Facility Name (i	If not institution, g	give street and nur	n <i>ber)</i>		4b. City,	Town, or L	ocation o	of Death			ounty of Deat		
		Salisburg	Rehabi					alis	bu	54		U	)icon		
Funeral Director		5. Social Security N 214-32-14		Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. <b>74</b>	ia <i>st</i> birthday Yrs.	/) If Under Months	Days	Hours Hours	Min.	8. Date of Bir (Month, Do Dec 23	ay, Year)	Co	thplace (State or For ountry)	eign
		Usual Residence of			/4						Dec 23	,1934	M	J	
yland		10a. State	10b. County		10c. Cit	ty, Town or L	ocation							10d. Inside City Lin	nits
e Mai 3a-f s	cto	MD	Wicomi	co	Sa	lisbu	ry							1 XYes 2□	No
ath with the Marylan 23a or 28a-f show ust be notified at	Dire	10e. Street and Nur					10f. Zip		_			10g. Citizer	n of What Co	ountry?	
ath w	ra	1815 Thor	nas Lane					2180					USA		
fter deat r items	Funeral Director	<ol> <li>Marital Status</li> <li>Never Marri</li> </ol>	ied 2X Married	Armed Fo		.S. 13	_		panic Ori , Mexicar	igin? (Spe n, Puerto	ecify Yes or No Rican, etc.)	o- 14.	. Race - Ame Black, White	e, etc.	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Martical Evanting rough is published and once.	d by	3 🗆 Widowed		If Yes, Giv Year or Da	ve ates:		1 □Yes 2		Specify:			St	pecify: B.	lack	
"nati	Completed	(Spec	15. Decedent's cify only highest of	Education grade completed)		I (Giv	edent's Usua e kind of wor DO NOT us	k done du		t of worki	ing	16b. Kind	of Business/	Industry	
withii iene. than	E	Elementary/Seco	ndary (0-12)	College (1	-4or 5+)	me.		ervis	cor			Food	d Proce	accina	
filed I Hyg other ent, I	BeC	17. Father's Name	(First, Middle, La	st)			Dup			er's Name	(First, Middle			casing	
uld be Menta irked itic ev	To B	Norman Ga	aile, Sr	•					Anna	a Mae	Jones				
2 sho and l		19a. Informant's Na									al Route Numb			Zip Code)	
l and Health em 27 ther tr		Jo Irene			not f				ne, s		sbury,			T	
ages ant of l			Cremation 3	Removal from 5	_	emetery, ch inahi	position (Name ematory or of L1 Mem	her place			Date	20c. Loca	tion - City or	Town, State	
mit. F partme oortan Injur		21. Signature of Fu	5 Other (Specification 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5			Gard	dens	-	of Facilit	7/3/2	2009	Hebr	con, Mo	d	
permi Depar Impor any Ir		Tala	11a DU	hlood			Lewis 1618 W	N. Wa est F	atsor Rd.,	i Fur. Sali	eral H	ome, E MD 21	PA ∤801		
		23a. Part 1. Enter to shock, or hea	he disease, or co irt failure. List on	mplications that cally one cause on e	aused the deat ach line.									Approximate Interval Between	
Physician		Immediate Cause	(Final	Con	Ja 014	1	fa		2	)	ever	1		Onset and Death	1
/Medical Examiner		resulting in death)	4	Due to (	or as a cons q	uence of):		7					1		
Lxammer	<u></u>	Sequentially list con	nditions,	b	nd it	29	170	rlflig						gea-	
nsit	Examiner	cause. Enter Unde Cause (Disease or	rlying Injury	Date to f	or as a sonseq	deries of									
execu n and ial-tra	Exal	that initiated events ' c. resulting in death) Last Due to (or as a consequence of):													
cate be executed physician and the burial-transit	dical			d											
rtifica ng ph as th	0.0	IE EENAN E			- 0.0%-										
leath certific attending p	an	IF FEMALE: 23b. Was decedent in the past 12		23c. If yes, outo	come of pregna		☐ Ectopic p	regnancy				230	d. Date of del		
the at the at	Physician/M	1 Yes 2 9 Unknown	□No		nant at time of o		Other (sp						Month	Day Year	
that the		Part II. Other signif		contributing to de	eath but not res	ulting in the	underlying ca	use given	in Part I.	*	23e. Did	tobacco use	contribute to	the cause of death	?
w requires that the di been signed by the should be detached	d by					_					1 🗆	Yes 2 ☐	No 3 □ Pr	obably 4 🗍 Unkno	own
aw rec	Completed										24a. Was		24b. Were au	topsy findings availa	able
The law ate has page 2 s	E										auto perfo	psy ormed? 2 🖺 No	death?	completion of cause 2 □ No	of
siclan: The certificate rector, pag	BeC	25. Was case refer	red to medical						26. Place	of Death	(Check only		- I Lites	2 1110	
hysic his ce I dire		examiner? 1 ☐ Yes 2 🕞	No	Hospital: 1 □ I	npatient 2 🗆	ER/Outpation	ent 3 DO	A Other	: 4 🖪 Nu	arsing Ho	me 5 🗆 Resi	idence 6	Other (Spe	cify)	
ding Physiclan: th. : After this certific: funeral director, I	ü	27. Manner of Death	h 5 🗌 Pending	28a. Date of (Mont	of Injury h, Day, Year)	28b. Time Injury	-	Bc. Injury a Work?	at	1	28d. Describe	how injury o	ccurred		
tendi leath. tor: / the fu	cati	2 ☐ Accident 3 ☐ Suicide	investigati 6 ☐ Could not	he			М		es 2 🗆 I						
To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  To thin Euneral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Certification: To	4 Homicide	determine	d 28e. Place	of Injury - At ho ng, etc. <i>(Specit</i>	ome, farm, s	treet, factory,	office			28f. Location ( City or To	Street and N wn, State)	Jumber or Ru	ural Route Number,	
ospita hours uneral iy fille		29a. Certifier (Check only	1 Certifying I	Physician: To the	best of my kno	wledge, dea	th occurred	at the time	e, date ar	nd place,	and due to the	cause(s) ar	nd manner as	s stated.	
the Ho nin 24 the Fu	Medical	one)	ZLI Medical Ex	aminer: On the ba and mann	asis of examina ner stated.	ition and/or	nvestigation,	in my opi	inion, dea	ath occurr	red at the time,	, date and pl	ace, and due	to the cause(s)	
To with	2	29b. Signature and	title of certifier	111			290	License I	number	9	2	29d. Date s	signed (Montl	h, Day, Year)	
5501		100		16hor			1	> 2	- 1	28	1	4/2	6/09		
~ Du		30. Name and addr	115	1 -	e of death (Iten	n 23a) (Type	, Print)	- N		C	Colo	Α.	~ -	110011	
Sta	te	31. Date filed (Mont		32. R	egistiai s olytia	ture A	JIV U	ナイド	ve.	Ja	HSDU	CA1V	IDa	11804	
Registra		,	IIIN 2	2009	BALLAND	14. 4	7								

DHMH 17 Rev 1/2001

Elmer Gaile

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Marylar	-	artment of F r <i>tificate of l</i>		-	giene Reg. No.!	2000	22220
			Decedent's Name (First, Middle, Last,	)	-			2. Date of Dea	ath <sup>1</sup>	<del>2 U U 3</del> -	3. Time of Death
	Physicia /Medic		CATHERINE E. GSE	LL				JUNE 18	Day 20	Year 109	1:50P M
-	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c.	County of Death	
est."			100 CEDAR STREET  5. Social Security Number 6. Secu	7 //-	la a t h inth da)	CHESTERTOWN  thday) If Under 1 Year   If Under 24 Hrs.   8, Da			KENT		
	Funeral Director			7. Age (in yrs	. last birthday) Yrs.	8. Date of Birth (Month, Day, Year) FEB. 4, 1919 9. Birthplace (State or Foreig Country) MD					
	fand ow		10a. State 10b. County 10c. City, Town or Location								I Od. Inside City Limits
	Mary	tor	MD KENT	C	CHESTER	TOWN					1 XYes 2 □ No
	th the	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	zen of What Cou	ntry?
	ath wi		100 CEDAR STREET			21620				JSA	
5-0036	Irs a	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1	J.S. 13.	ecify Yes or No- Rican, etc.)		14. Race - Ameri Black, White, Specify: WH			
2-0	72 ho	eted	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dece	dent's Usual Occup	ation during most of worki d)	ina I	16b. Kir	nd of Business/In	dustry
121	I within 72 ho giene. r than "natur	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			1)		OUR	LUOME	
2	be filed v ntal Hygis od other I event, III		12 17. Father's Name (First, Middle, Last)		HOM	EMAKER	18. Mother's Name	(First, Middle,		HOME Surname)	
Maryland	و فر الم	To Be	HARRY KRAMER				BELLA C	GROVES			
ary	2 should and Mer is marke aumatic	_	19a, Informant's Name/Relationship (Ty	pe. Print)	19b. Mailir	ng Address (Street	and Number or Rura	al Route Numbe	er, City or	Town, State, Zij	o Code)
	s 1 and 2 should f Health and Mei item 27 is marke other traumatic		DEBORAH CARTER/DA				LEVILLE,	MD 2191			
Baltimore,	e = 1.3e		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F	20b. Removal from State	Place of Dispo cemetery, cres	sition (Name of natory or other plac	e)	Date	20c. Lo	cation - City or To	own, State
≣	it. Pag rtmen rtant; rjury		4 ☐ Donation 5 ☐ Other (Specify)	CH		CEMETERY	6/23/	/2009	CHES	STERTOWN	, MD
Ra	permit. Pag Departmen Important: any injury once.		21. Signature of Funeral Service Licens	99	F	P. Name and Address ELLOWS, H 30 SPEER	ss of Facility IELFENBEIN RD. CHEST	N & NEWN	IAM I MD	UNERAL 21620	HOME
			23a. Page 1. Enter the disease, or compl shock, or heart failure. List only or	cations that caused the dea	th. Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
	hysician		Immediate Cause (Final disease or condition resulting in death)	Chronic	Obs	truetmã	Valma	un Do	See	u	Onset and Death
	/Medical Examiner		resulting in dealin)	Due to (or as a consec	quence of):			,			,
		ē	Sequentially list conditions, if any, leading to immediate	). Due to (or as a consec	quence of).						
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
Š,	tificate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as a consec	quence of):						
09/89	cate b	ledical		d							
×	leath certific attending p		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn		∃ Ectopic pregnanc	v		2	3d. Date of deliv	•
	it the death of the by the attentached for us	hysician/M	1 ☐ Yes 2 ☐ The 9 ☐ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5	Other (specify)				Month	Day Year
Ś.	es tha igned be de	by P	Part II. Other significant conditions con	ntributing to death but not res	sulting in the u	nderlying cause give	en in Part I.	¥	~		he cause of death?
0	een s	ted	Artenosterite	c (ordroves	ular	Deser		1/21	es 2[	∏No 3∏ Pro	bably 4 Unknown
II Records	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Completed						24a. Was autop perfo 1 🗆 Yes		24b. Were auto prior to co death? 1 □ Yes	opsy findings available ompletion of cause of
VITAI	ician: sertific ector,	Be (	25. Was case referred to medical examiner?	In a situal		I au	26. Place of Death	(Check only o	ne)		
0	Phys rthis ral dir	<u>٩</u>	1 Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatier 28b. Time of		4 LI Nursing Ho	me 5 Resid		Other (Speci	fy)
5	ding th. After fune	ţi	1 Natural 5 Pending 2 Accident investigation	(Month, Day, Year)	Injury	Work	yai (? Yes 2 □ No	zou. Describe r	iow injury	occurred	
DIVISION	Atter	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	lome, farm, str	eet, factory, office				d Number or Run	al Route Number,
5	ral or rs after al Dir	Sert					City or Tou				
	n 24 hount 124 hount 124 hount 124 hount 124 hount 124 hount 124 hount 124 fill	Medical	29a. Certifier  (Check only one)  1 Certifying Physical Examination (Check only one)	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, deatl ation and/or in	n occurred at the tir vestigation, in my o	me, date and place, pinion, death occuri	and due to the red at the time,	cause(s) date and	and manner as place, and due t	stated. o the cause(s)
	vithi com	Ž	29b. Signature and title of certifier	1 (nD)		29c. License	e number	ph.	29d. Dat	e signed (Month,	Day, Year)
	10	-	30. Name and address of person who co		m 23a) (Type,	Print)	04	1 /			
	ms		31 Date filed (Month Day Year)		)oshre		· Clerk	before	m	d 2162	20
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signar	ature A.	port					
D. I. II.				7							

# ■ Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	Registrar  1. Decedent's Na	me (First, Midd	lle, Last)			Cei	rtificate c	or Death	,	2. Date of De			3. Time of Death
ian ical	JESSE	WILLI	IS HAM	MOCK						JUNE	24 Day	2009	5:27 I
iner	4a. Facility Name			and number)	)		4b. City, Town, or Location of Death  QUEENSTOWN				4c.	QUEEN A	
!	5. Social Security	Number	6. Sex	7. Ag	ge (In yrs. las	st birthday)	If Under 1 Ye	ar   If Unde	r 24 Hrs.	8. Date of Bir	8 Date of Birth 9 Birthplace (State		
r	264-60-	-2016	1 X M 2	□F	68	Yrs.	Months Da	ys Hours	Min.	(Month, Da	15,1		untry) ORIDA
	Usual Residence	of Decedent 10b. County	/		10c. City,	Town or Lo	ocation				_		10d. Inside City Lim
ţ	MD	QUEEN	ANNE'	S	QUEE	NSTOW	'n						1 ☐ Yes 2 <b>X</b> ☐
Director	10e. Street and N						10f. Zip Cod			T	10g. Citizen of What Country?		
rall	120 TA	AYLOR DE				er in U.S. 13. Was Decedent of Hispanic Origin? (Sou						USA	
Funeral	11. Marital Status	s arried 2 <b>X</b> Mar	Ar	as Decedent med Forces? ]Yes 2 <b>X</b>	Ever in U.S.  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto				Rican, etc.)	)-	<ol> <li>Race - Amer Black, White</li> </ol>	e, etc.	
þ	3 ☐ Widowed	4 Divorced	lf Y	es, Give ar or Dates:			1⊡Yes 2 <b>∏</b>	No Specify	<i>/</i> :			Specify:	WHITE
Completed	(Sp	15. Deceder	nt's Education	oleted)		16a. Decedent's Usual Occupation (Give kind of work done during most of work)				ing	16b. Kir	nd of Business/l	ndustry
I di	Elementary/Se	condary (0-12)	Co	llege (1-4or 5	5+)		DO NOT use rei	tired)			H	ORSE RAG	CTNG
Be Co	17. Father's Nam	e (First, Middle,	, Last)	-0-			JOCKEY _	18. Moth	ner's Name	e (First, Middle			OINO
To B	BLANTO	ON HAMMO	OCK					l M	1ADDI	E IRENE	HOD	GES	
Γ	19a. Informant's	Name/Relations	,	int)			ng Address (Str					r Town, State, Z	?ip Code)
	20a. Method of D		/ WIFE		20b. Plac	ce of Dispo	sition (Name of			Date		cation - City or 7	Town, State
	1 ☐ Burial	2 X Cremation 5 ☐ Other (5		al from State	CHES	APEAK	matory or other E CREMA	olace)	JUNE	26,200	STI	EVENSVII	LLE, MD
	21. Signature of				CENT	22	2. Name and Ad						
	<b>P</b> (	'L'DEN	er	<1	قاور		LLOWS,H	ELFENE	SELN (	CTATTOE	M PU.	E, MD 2	OME, P.A. 1617
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je.	resulting in death	n)	b	Due to (or as Lunら		657e ince of):	ICTVE				152	A3E	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 18,2009 Year **Physician** Nicolas June 10:05a M Herrera /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4613 Brad Court Rockville Montgomery 8. Date of Birth (Month, Day, Year) 9 / 09 / 1925 Social Security Number 218-19-4164 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days 83 Months Hours Min. 1 X M 2 □ F Director Peru Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f shorevent, the backles Eval, the motified at MD Montgomery Director Rockville 1 Yes 2 □ No 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 4613 Brad Court 20853 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian within 72 hours after 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X** No Baltimore, Maryland 21215-0036 1⊠Yes 2□No Specify: Peruvian 2 Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) Floral Work Florist is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event Be Emitrio Herrera Petronila Torres ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Victor Herrera/Son 14105 Parkvale Rd.Rockville,Md.20853 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven 6/22/2009 Silver Spring, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Vuneral Service Lo PHILIP AD RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia wk /Medical Due to (or as a consequence of): Examiner Aspiration Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Parkinson's Disease and burial-trar Due to (or as a consequence of) Box 68760 the attending physician certificate be Physician/Medical the as nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy or in the past 12 months? Dav Year 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a o 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed <del>Dementia</del> 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate perform Vital 2 **K** No 1 □Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 WOther (Specify Ssisted ٩ 1∐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA oţ this 28a. Date of Injury (Month, Day, Year) living 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and tille of certific 29c. License number 29d. Date signed (Month, Day, Year) ٥ June 22,2009 who completed cause of death (Item 23a) (Type, Print) 30. Name and Ernesto Africano M.D. 344 University Blvd West #211 Silver Spring, Md 31. Date filed (Month, Day, Year) 32 Registrar's Signatu State JUN 2 R 2009 Registrar

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Completed by Funeral

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**Physician** 

/Medical

**Examiner** 

**Funeral Director** 

State Registrar			(		ment of F icate of	Death	-	Reg. No.	nng	2221
. Decedent's Name (First, Middle	e, Last)		-	_			2. Date of Dea		Year	3. Time of Death
Jesse Jacob Ra	y HURD Sr	•					June	28		11:26 AM
Facility Name (If not institution	n, give street and nu	m <i>ber)</i>		4b.	. City, Town, o	r Location of Dea			ounty of Death	
Washington Cou	nty Hospi	tal			Hagers	stown		Wa	ashingt	on
Social Security Number	6. Sex	7. Age (In y		Mo	Under 1 Year onths Days	If Under 24 Hrs Hours Min	(Month, Da	v, Year)	Coui	
12-24-7387	1 <b>X</b> M 2 □ F	78	Yr	rs.	Days	I IVIII	Sept. 2	8,193	0 Ma	aryland
a. State 10b. County		100	City, Town o	or Locatio	on.				11	10d. Inside City Limits
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e. Street and Number				1	0f. Zip Code	217/0		•	n of What Cour	ind y'f
16900 Lakeview				12 1::		21740	0 " "	USA		
. Marital Status	12. Was Dece	rces?	U.S.	13. Was If Yes	Decedent of H s, specify Cub	Hispanic Origin? ( an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	-   14	<ul> <li>Race - Americ</li> <li>Black, White,</li> </ul>	
1 Never Married 2 Marr	If Yes, Gi	ve		1 🗆 ነ	Yes 2⊠No	Specify:		S	pecify:	white
3 ☐ Widowed 4 ☐ Divorced	Year or D	ates:	100 5	)aaadaat	'a Houst Ossess	nation			of Business/In	
15. Decedent (Specify only highes	rs Education of grade completed)		1 (	Give kind	's Usual Occup I of work done NOT use retire	during most of we	orking	IOD. KING	or business/in	auustry
Elementary/Secondary (0-12)	College (	1-4or 5+)	,		inter	u)		pair	nting	
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Elmer Leon Hu						1	s Pauline		,	
			105 1	Apilian *	ddenes /Circ-i	-	Rural Route Numbe			n Code)
ea. Informant's Name/Relationsi <b>Genevieve E.</b> H		0		-			, Hagerst	-		
Da. Method of Disposition	uru - WII						Date Date		riar y ra	
a. Method of Disposition 1 □ Burial 2 ☒ Cremation	3 Removal from	State I			n (Name of ory or other place	ce)	Date	ZOG. LOGS	mon - Ony or 10	omit, otate
4 ☐ Donation 5 ☐ Other (S <sub>i</sub>	pecify)	H	agers	+ a		. فیصا	20100			
			0		Cremat		30/09			Maryland
. Signature of Funeral Service	Licensee		0	22. Na	ame and Addre	ess of Facility	MINNICH I	FUNERA	AL HOME	
1. Signature of Funeral Service	Licensee		0 1	22. Na	ame and Addre	ess of Facility		FUNERA	AL HOME	21740
Fred Lu	complications that of	caused the de		22. Na	E. Wil	ess of Facility 1	MINNICH I d., Hager	FUNERA stown	AL HOME	21740 Approximate Interval Between
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To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra attending physician for use as the buria the is certificate has been signed by director, page 2 should be detact this After this funeral of within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

**Physician** 

Immediate Cause (F disease or condition resulting in death) /Medical **Examiner** Sequentially list con-il any, reading to infini-cause. Enter Underl Cause (Disease or in that initiated events resulting in death) La Examine Physician/Medical IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ☐ 9 Unknown Part II. Other signifi Be Completed by (3) 25. Was case referre examiner? Medical Certification: To 1 ☐ Yes 2 ☐ 27. Manner of Death 1 Natural 2 Accident 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

54-10

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PRANCISCO ANDRADE 350 MILL ST. JUN 3 0 31. Date filed (Month,

HAGERSTOWN, M.D. 217KO 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

For State Registral Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2009 JUNE 13, **Physician** 02:38A M HOWARD JOHN HOLLINGSWORTH /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CECIL ELKTON CARE AND REHAB ELKTON Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5 Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 ☐ F Months Director 6/4/1922 87 221-14-0712 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Director KENT GALENA 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 12344 CHESTERVILLE RD. USA 21635 Completed by Funeral 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ¼ Yes 2 □ No If Yes, Give Year or Dates: ₩₩II 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: WHITE 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) TRANSPORTATION 12 TRUCK DRIVER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be famen of Health and Mental Fint: If item 27 is marked or HOWARD JOHN HOLLINGSWORTH MILDRED SLAUGHTER ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12344 CHESTERVILLE RD. GALENA, MD 21635 RUTH HOLLINGSWORTH/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Importent: If it any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State \*4 □ Donation 5 □ Other (Specify) CHESAPEAKE CREMATION | 6/16/09 STEVENSVILLE, MD 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME
5/0 w. CYPRESS SI. MILLINGTON, MD 21651 21. Signature of Funeral Service Licensee Feller att. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Chronic **Physician** /Medical Due to (or as a consequence of): **Examiner** aurenna Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed burial-transit Due to (or as a consequence of): the attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Vital Records, The law requires 1 Yes 2 No 3 Probably 4 Onknown Completed the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 2 No Phyaician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 은 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Division of this 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 27. Manner of Death After Hospitel or Attending 5 Pending investigation 1-Natural 1 🗌 Yes 2 No after death death 2 Accident 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide City or Town, State) 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) completely within 2. To the I To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 6.13.00 D26183 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 322 East Cecil Ave North East, MD 21901 Madho S. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

P.O. Box 68760.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 1151 PM **Physician** essie 16 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 54 Gambrills Rd. Anne Arundel Severn If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 12/29/1916 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Hours Min. 1 ☐ M 25€F 92 MD 215-09-8093 Director Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location MD Anne Arundel Severn 1 Yes 2XXNo Directo 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code USA 21144 54 Gambrills Rd. by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2√TXNo If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 🔼 No Specify: **¾** Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William T. Crouse Anna Hopf ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 54 Gambrills RD. Severn, MD 21144 Becky Stephens Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages 1
Department of H
Important: If ite
any injury or oti
once. 1 ☐ Burial 2 🗗 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/18/2009 Glen Burnie, MD Atlantic Crematory 22. Name and Address of Facility Hardesty Funeral Home, P.A. 21. Signature of Funeral Service Licensee Annapolis, MD 21401 12 Ridgely Ave. 23a. Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 3 No 3 ☐ Probably 4 Unknown ailable use of 25 Be Certification: To 27

To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Division of Vital Records, P.O. Box 68760, attending p for use cate has been signed by the page 2 should be detached After this within 24 hours after death

To the Funeral Director:
completely filled in by the

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ury or other thaumatic event, Ite Medical Examiner must be rediiled at ury or other traumatic event, Ite Medical Examiner must be rediiled at

Baltimore, Maryland 21215-0036

					24a. Was an autopsy performed? 1 □ Yes 2 ☑ No	24b. Were autopsy findings av prior to completion of caudeath? 1 □ Yes 2 □ No
. Was case referred to	medical			26. Place of Dea	th (Check only one)	
examiner? 1 ☐ Yes 2 ☐ No	H	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 🗆 🛭	OOA Other: 4 In Nursing H	lome 5 Residence 6	i ☐ Other (Specify)
2 Accident	Pending investigation	(Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □Yes 2 □ No	28d. Describe how injury	occurred
	Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, street, facto	ry, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Numb
	400	i i				

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License numb

State Registrar

Medical

(Check only

29b. Signature and title @

eter 31. Date filed (Month, Day, Year) JUN 19 2009

Name and address of person who completed cause

(Item 23a) (Type, Print)

			Plea										re Legible.		
		For State Registrar			State of	Maryia			ment of <i>icate of</i>		d Mental	Hygie Reg.		00015	
		1. Decedent's Nam	e (First, Middle	, Last)							2. Date of		2009	3_Time of Death	
Physicia /Medica		S	SEBRON			ISOM				JUNE		Day Year 19 2009	10:36 P <sup>M</sup>		
Examine		4a. Facility Name (i	If not institution	, give st	reet and numi	ber)		4b	. City, Town,	or Location of D	eath	eath		ath	
		WASHINGTON ADVENTIST HOSPITAL							TAKOMA PARK				MONTGOME	ERY	
Funeral		5. Social Security N	lumber	7	. Age (In yr	s. last birth		Under 1 Year onths Days		Hrs. 8. Date of	f Birth	9. Bi	rthplace (State or Foreign country)		
Director		417-38-0	0651	1 L.	X <sup>M 2□ F</sup> 76 Yrs.			rs.	Jillis Days	riours	AUG.	9 1	932 AL	BAMA	
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is a	by Funeral	11. Marital Status 1 □ Never Marr 3 ☑ Widowed	_		2. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Dat	es? □ No AR	i? ]No ARMY If Yes, sp 1 □Yes			oan, Mexican, P	? (Specify Yes of uerto Rican, etc	or No- .)	14. Race - Am Black, Whi		
2 ho	Completed I	(0	15. Decedent	's Educa	ation		16a. D	Decedent'	s Usual Occi	pation		16	b. Kind of Business	s/Industry	
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sholand l	'	19a. Informant's N	ame/Relationsl	пір (Тур	e. Print)			-					ity or Town, State,	Zip Code)	
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of He		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or cemetery, crematory or other place)									r Town, State				
Page nent int: If		1 LX Burial 2 I 4 ☐ Donation			moval from St	ate   F	-			TERY 6/	27/09	В	RENTWOOD,	MARYLAND	
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Physician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. ASPIRATION PNEUMONIA										Approximate Interval Between Onset and Death			
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was deceden in the past 12 1 ☐ Yes 2 [ 9 ☐ Unknown	months? ⊒No	23	c. If yes, outco 1  Live bir 4  Pregna 9  Unknov	th 2☐Fe nt at time o	tal death		topic pregnar ner <i>(specify)</i>	су	,	_	23d. Date of delivery Month Day Year		
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within comp	ž	29b. Signature and	title of certifier						29c. Licer	se number			. Date signed (Mor		
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31. Date filed (Month, Day, Year)
JUN 2 9 2009 State Registrar

VINCENT D. HAYES M.D. 7600 CARROL AVENUE TAKOMA MARYLAND 20912 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Time of Death 2. Date of Death Day 2009 JUNE 21 10:32AM OLIVER JOY JR. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death CHARLOTTE HALL NURSING HOME ST. MARY'S CHARLOTTE HALL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) JAN 5 1931 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 1 ₹M 2 ☐ F WASHINGTON, DC Yrs. 78 579-36-8043 Usual Residence of Decedent 10a, State 10h Count 10c. City, Town or Location 10d. Inside City Limits 1 HYes 2 □ No ANNE ARUNDEL **PASADENA** 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 225 KENWOOD ROAD 21122 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married BLACK 1 ☐ Yes 2 🛣 No Specify: 3 ☐ Widowed 4 🎇 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th MAINTENANCE ENGINEER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) OLIVER J. JOY SR. ZADIE OZELL JONES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LAWANDA JOY-BELL/DAUGHTER 225 KENWOOD ROAD PASADENA, MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State RIVERDALE CREMATORY 6/26/2009 RIVERDALE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) ignal re of Funeral Service Ucensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COPD disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ulmonary Due to (or as a purse juence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year

Physician: The law requires that the death certificate be execute burial-tran Division of Vital Records, P.O. Box 68760, physician the attending pl signed by the a d be detached f been certificate has To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this

Examine Physician/Medical Medical Certification: To Be Completed by

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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7 is marked other traumatic event.

permit. Pages 1 and Department of Health Important: If Item 27 any injury or other to once.

Physician

Examiner

/Medical

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event, the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with the ment of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

Directo

Funeral

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State Registrar

9 Unknown	9 ☐ Unknown	The (openly)	
Part II. Other significant conditions	contributing to death but not resulting in the unde	erlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
			24a. Was an autopsy performed?  1 ☐ Yes 2 ☐ No  24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No
25. Was case referred to medical examiner?		26. Place of De	ath (Check only one)
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 ☐ DOA Other: 4 ☑ Nursing I	Home 5 ☐ Residence 6 ☐ Other (Specify)
27. Manny r of Death 1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injury occurred
3 Suicide 6 Could not determine		, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one)	Physician: To the best of my knowledge, death o aminer: On the basis of examination and/or investand manner stated.	ccurred at the time, date and place stigation, in my opinion, death occ	e, and due to the cause(s) and manner as stated.  urred at the time, date and place, and due to the cause(s)
29b. Signature and title of certifier	Þ	29c. License number  W78/14	29d. Date signed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day JUN 2 8 2009

			For State	State o	of Marylan		artment of H		and M	•	•			
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п	Physici	an								<ol><li>Date of De Month</li></ol>	Day	Year	3. Time-of	
-	/Medic		JACQUELYN	A. JUPI						June	19,	2009	9:57	P M
	Examin	er	4a. Facility Name (If not institution		ŕ		4b. City, Town, o	of Death		4c. County of Death				
Spirit.			Greater Balt				Towson		04 (100			timore		
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 21 F	7, Age (In yrs.		If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Bir (Month, Da	iy, Year)	Cou	olace (State o	r Foreign
	Director		178-44-2247			55 Yrs.				JULY 2	, 1953	LIBE	RIA	
	and *		Usual Residence of Decedent  10a. State 10b. County	v	10c Cit	ty, Town or Lo	cation						I 0d. Inside Cit	tv Limits
	sho	ō	MD BALTI			TIMORE							1 ∰Yes	
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	death with the Maryland ims 23a or 28a-f show	ä	10e. Street and Number 6920 DONACHIE I	SD.			10f. Zip Code 21239					of What Cou	,	
	ath v	Funeral	OJZO DOMIONILI I	T								ED STA		
_	tem:	un	11. Marital Status	Armed Fo			Was Decedent of H If Yes, specify Cub	lispanic Ori an, Mexicar	igin? (Spe n, Puerto F	cify Yes or No Rican, etc.)	14.	Race - Ameri Black, White,		
36	s affe	by F	1 Never Married 2 Ma	If Yes, G	ive		1 □Yes 2¥ No	Specify:			Sp	ecify:BLAC	!K	
5-0036	72 hours after natural", or ite dical Exactina	d b	3 ☐ Widowed 4 ☐ Divorce		Dates:									
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) ਵ	ould be filed withir I Mental Hygiene. narked other than natic event, II with	Be	17. Father's Name (First, Middle	, Lasi)						(First, Middle,		name)		
3	should and Mer marke umatic	은	CHARLES E. J			T				JOHNS				
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "naturar", or items 23a or 28a-f show other traumatic event, if a Photlest Expr. there must be notified at	Ι.	19a. Informant's Name/Relation			ł	ng Address (Street						o Code)	
	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau	1	MICHAEL JUPITER	/BROTHER			AMHERST		<u>.                                    </u>					
Baltimore,	Pages 1 nent of H ant: If iter ury or otl		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 ☐ Bernoval from	State 20b. F	Place of Dispo cemetery, crer	sition (Name of natory or other place	ce)	Di	ate	20c. Locati	ion - City or T	own, State	
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a t	permit. Departr Importa any Inju		21. Sign, ure of Funeral Service	e Licensee	// //	22	2. Name and Addre	ss of Facilit	ty CAF	ITOL M	ORTUA	RY.		
<u>m</u>	70 F # 9		MALIN	H., DO	DC 20002									
			23a. Part 1. Enter the disease,	r complications that	caused the deat	h. Do not ent	er the mode of dyi	ng, such as	cardiac o	r respiratory a	rrest,		Approximate Interval Bet	e ween
Tage	Physician		Immediate Cause (Final	shock, or heart failure. List only one cause on each line. mediate Cause (Final sease or condition Sease or condition Sease or condition									Onset and [	
	/Medical		resulting in death)		(or as a conseq	-	PSIS						1 day	
7	Examiner			b. Wrin		to A	· ·	+					V	)
	-0-0	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		(or as acconseq	uence of):	17114	C [112 K						
	uted d ansit	Ē	Cause (Disease or injury											
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8760,	icate be executed physician and the burial-transit	dical		d										
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Box	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna						23d	. Date of deliv	erv	
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٦,	ires that signed b		Part II. Other significant condit	ions contributing to d	leath but not res	ulting in the u	nderlying cause giv	en in Part I		23e. Did 1	tobacco use	contribute to	the cause of d	death?
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Division	ter di irect irect	Certification: To		mined   28e. Place	e of Injury - At he ling, etc. (Specif	ome, farm, str	eet, factory, office		2	28f. Location ( City or To	Street and N wn, State)	lumber or Rui	al Route Num	nber,
	ital cristafral D	Se		4						ŕ		_		
	t hou t	cal	29a. Certifier 1 Certify (Check only 2 Medica	i <b>ng Physician</b> : To the l I Examiner: On the l	e best of my kno	wledge, deat	h occurred at the ti	me, date a	nd place, a	and due to the	cause(s) ar	nd manner as	stated.	e)
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	one)	and mar	nner stated.			- pori, ucc			, saw and pie			′
_	With Con	Σ	29b. Signature and title of certific	er			29c. Licens	se number			29d. Date s	igned (Month	Day, Year)	
			marie (	authom	_		D:	209	07		6/2/1	09		
6	6		30. Name and address of person	n who completed cau	se of death (Iten	n 23a) (Type,	Print)		r> .	2				
14	V		Marie C	hatham	6	701	N Charle	S S	st it	BoH.m	6 19.	Md 2	1204	
	Sta	te	31. Date fifed (Month, Day, Year	) 32. F	Registrar's Signa	ature.		_		, - 51	,			
	Registr	ar	MIN 3 0 2009	Maria.	A ALCO	de								

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2009 Month **Physician** Glenneatte JOHNSON June 27, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 19101 Rock Maple Drive Washington Hagerstown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or For Country) | April 23, 194 | Mississippi 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 366-52-3124 1 M 2 X F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Director Washington Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 19101 Rock Maple Drive 21742 U.S.A. Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify Specify: black þ 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker her own home 12 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Glennie Payton Beatrice Newman ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) David Johnson - husband 19101Rock Maple Drive, Hagerstown, Maryland 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 2909 June 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland fred a Vistal 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 Yes 2 Hb 9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9☐Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1∐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 200 Hospital: 1 ☐ Yes မှ 1 🗍 Inpatient 2 ER/Outpatient 3□ DOA 5 Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours are. To the Funeral Dir

To the Hospital or Attending Physiclan: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifie

31. Date filed /Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 32. Pegistrar's Signature

and manner stated.

MO

CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 20ď§ 12:20 P M June 26, HOWARD HANFORD KELLY, III /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NMS Health Center Hagerstown Washington if Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or For Nov. 16, 1957 Pennsylvania 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 1**⅓**M 2□F 216-70-0255 51 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County "natural", or items 23a or 28a-f shovedical Examiner must be notified at 1 Yes 2 No Director Frederick Maryland Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 120 East Patrick Street 21701 U.S.A. Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ☐ No Specify: ģ 3 ☐ Widowed 4 A Divorced White Completed Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) the Me College (1-4or 5+) Elementary/Secondary (0-12) Glazier Custom Glass event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 27 is marked of traumatic even Miriam Young Howard H. Kelly, Jr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 120 East Patrick Street, Frederick, Maryland 21701 Susan Kelly / Ex Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State Mt. Olivet Cemetery 6/29/09 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 21. Signature of Funeral Service 22 Name and Address of Facility & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET STREET, FREDERICK, MD 21701 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Demente **Physician** Advance 7 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 2 4 10 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Hospital or Attending Physician; The law requires that the death certificate be executed physician and s the burial-transit Division or Vital Records, P.O. Box 68760, nding I signed by the at the detached for certificate ha After this death. after death Director: filled in by 24 hours a within 24 ho

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the Maryland

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier met mo D0018019

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HAG MD 21740 DATTA

31. Date filed (Month, Day, Year) JUN 29 2009 Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Ye ar Month Physician 24,2009 June Ι Lilia /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges Lapham Doctors Community Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. 5. Social Security Number **Funeral** Months Days Hours 1 □ M 2 😡 F 65 April 1,1944 Thailand Director 218-82-9640 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show "natural", or items 23a or 28a-f shovedical Expenses to refified at 1√2 Yes 2 □ No MD Prince Georges Brentwood Director 10g Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 1 and 10 cliently and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or : ury or other traumatic event, Ite Medical Examiner mast war. United States Funeral 20722 4311 Lawrence Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Specify 1 ☐ Yes 2 ☑ No Specify: þ Asian 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private 12 Vendor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၀ Indode Watlin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 shr Department of Health and Important: If item 27 is many injury or other traumonce. 19a. Informant's Name/Relationship (Type. Print) Eddie Lilja/Son 6615 Magnolia Terrace Lanham M.D. 20706 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Crematory 7-2-2009 | Brentwood M.D. 4 ☐ Donation \_ 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service Linensee 3401 Bladensburg Rd Brentwood M.D. 20722 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PTIC Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): physician au the burial-t Completed by Physician/Medical attending p for use as t IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) by the a 2 😾 No 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Thknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □ No 24a. Was an autopsy performed? Yes 2 100 has NEUMONI 1 Tyes 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Mnpatient Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Mann Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 24 hours after death. e Funeral Director: After letely filled in by the funera

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Baltimore, Maryland 21215-0036

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) 30. Name and address of person why 210 118 (500d) LALAM N 31. Date filed (Month, Day, Year)
JUN 3 0 2009 32. Registrar's Signature

State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2009 **Physician** June 11:30A M James Richard Long /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 17600 College Road Hagerstown Washington 8. Date of Birth
(Month, Day, Year)
JULY 26, 1930 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Maryland Months Days Hours 1**XX**4 2□ F 78 Yrs. **Director** 214-28-0592 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. Count or 28a-f show the Medical Exeminer must be notified at 1 ☐ Yes 2 X No Director Maryland <u> Hagerstown</u> Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zîp Code 230 21740 USA 17600 College Road death 12. Was Decedent Ever in U.S.
Anned Forces?
14∑Yes 2☐No 195
If Yes, Give
Year or Dates: 195 Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Items 11. Marital Status 72 hours after 1953-1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify. þ 3 ☐ Widowed 4 ☐ Divorced 1958 White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) e filed within al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Heating and A/C Installation Mechanical Engineer 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mental H is marked of Chester Arthur Ethel May Rodgers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s if Health an item 27 ls Hagerstown, Maryland 21740 Elizabeth A. Long - Wife 17600 College Road 20a. Method of Disposition

2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of F
Importent: If ite
any injury or ot
once. ' 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery July 2, 2009 Hagerstown, Maryland 21. Signature of Fyneral Servi OSDOTTIE FUTTER AT HOME, P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final + Cuth Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a const (tence of Examiner ician and burial-transit Due to (or as a consequence of): signed by the attending physician detached for use as the burial Box 68760 certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? Day 4☐ Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part IJ-Other significant conditions contributing to death but not resulting in the µnderlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Records. 1 Yes 2 No 3 Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 Yes 2 No langer of 1 🗌 Yes 2 No Division of Vital 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Yes 3 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 5 X esidence 6 ☐ Other (Specify) this 28d. Describe how injury occurred Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Hospital or Attending Pl 24 hours after death, Funerel Director: After t 5 Pending investigation 1. Natural 2 🗌 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Medical 29a. Certifier 1 🚅 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the the 29d. Date signed (Month, Day, Year, 29c. License number 29b. Signature and title of certifie 0 of death (Item 23a) (Type, Print) SH 5+1 455 In 11110 81. Date filed (Month, Day) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of M	laryland / I	Departme <i>Certifica</i>		lealth and N D <i>eath</i>		giene Reg. No.		
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387	phys phys s the	Physician/Medical		d								
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ğ	death atter	icia	in the past 12 months?	4□Pregnant	2 ☐ Fetal deat at time of death	th 3□Ectopic 5□Other		у		1	Month	Day Year
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<u>~</u>		Con							perf 1⊟ Yes	órmed? 2 <b>X</b> No	death? 1 ☐ Yes	2 No
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Division	or Attending after death. Director: After in by the fune	fical	3 Suicide 6 Could	not be 28e. Place of	injury - At home,				28f. Location	(Street and Nu	mber or Rui	ral Route Number,
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	To the Hospital or within 24 hours after To the Funeral Dirticompletely filled in I	Medical (	29a. Certifier 1 To Certifyir (Check only one)	ng Physician: To the be Examiner: On the basis and manner	s of examination a	ge, death occur and/or investiga	red at the ti	ime, date and place opinion, death occ	e, and due to the urred at the time	e cause(s) and e, date and plac	manner as e, and due	stated. to the cause(s)
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			30. Name and address of person	who completed cause of	f death (Item 23a	) (Type, Print)	<u> </u>	J . J		1		- 107.3
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month June 24, 2009 **Physician** 3:50 P M Joseph Lenk /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rockville Montgomery Casey House If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Oct 3, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs, last birthday, **Funeral** Days Hours 1 X M 2 □ F Virginia 51 Director 229-88-7701 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If Item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, Ite Medical Examinations and be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 ☐ Yes 2 ☑ No Director Calvert Huntingtown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 2810 Lookout Trail 20639 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2X No Specify Specify: White 2 3 ☐ Widowed 4 X Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Telecommunications Project Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carolyn Duncan Joseph Lenk ၀ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 209 Fountain Green Lane Gaithersburg, MD Monica Lenk/sister Baltimore, 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State permit. Pages Department o Important: If I any injury or once. Final Journey Crematory 06/25/09 | Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Give Homes Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician T Cell Lymphoblastic Lymphoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any art cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of). P.O. Box 68760. Physician/Medical the attending ph for use as th IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) I∐Yes 2□No signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has , page 2; autopsy certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director. 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Cother (Specify) hospice 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 Pending investigation n 24 hours a er death. Ie Funeral Director Aft bletely filled n by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) the within 7 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier . Koueltchou, ms June 25, 2009 NO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3

State Registrar

31. Date filed (Month, Day, Year) JUN 2 6 2009

parker

Jocelyne Kouatchou, M.D. 6001 Muncaster Mill Rd. Rockville, MD 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 0840M **Physician** AMBIRD TRICIA /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10,1932Months Days Hours 1□ M 2□F California June 530-18-5321 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show Item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examinat must be ruithed at 1 ☐ Yes 2 No Director Upper Marlboro Prince George's Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20772 16102 Ninean Court 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) h and Mental Hygiene. is marked other than umatic College (1-4or 5+) Elementary/Secondary (0-12) Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be file Iment of Health and Mental H tant; If Item 27 is marked oth Elizabeth Fitzgerald Russell Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 16102 Ninean Court, Upper Marlboro, MD 20772 Robert J. Lambird/Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ö 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pages
Department o
Important: If
any injury or
once. 06/19/2009 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) <u>Kal</u>as Crematory 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service License 2973 Solomons Island Road, Edgewater, MD 21037 Approximate nterval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician resulting in death) /Medical Cychon Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 Other (specify) ☐Yes 2 No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No certificate 1 ☐ Yes npletely filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐Yes 2☑No 1☐Inpatient 2☐ER/Outpatient 3☐DOA Certification: To this 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical mination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 Medical Examiner: On the basis of exa and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

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Nam and address of person who impleted cause of death (Item 23a) (Type, Print)

Date filed (Month, Day, Year)

32 Registrar's Signature

YET DEFENSE HIGHWAY ANNAPOUR MAZING

me 18 2009

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryla	-			lental Hy	giene	OOOCE
			State Registrar	Cer	tificate of L	<i>Death</i>		Reg. No.	3. Time of Death
	Physicia	ın.	1. Decedent's Name (First, Middle, Last)				2. Date of De Month	Day Year	
	/Medic	al	Margaret Larson	-Willer		1 1 ( D1)	July_	3 2009 4c. County of Dea	
	Examin	er	4a. Facility Name (If not institution, give street and number)			Location of Death			uri
and the same of th			SunBridge Care Center  5. Social Security Number   6. Sex   7. Age (In ye	s. last birthday)	E1kton	If Under 24 Hrs.	8 Date of Bir	Cecil 9. Bit	thplace (State or Foreign ountry)
	Funeral		5. Social Security Number  472−18−2375  6. Sex 1	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da DEC 22,	y, Year) 1919 Mii	ountry) nnesota
	Director		Usual Residence of Decedent				,		
	/land			City, Town or Lo	cation				10d. Inside City Limits
:	Mar a-f sh	tor	Delaware New Castle	Newark					1 □ Yes 2 No
	or 28s	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of What C	
	23a c		203 Aronimink Drive		19711			United S	
	ems ems	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Race - Am Black, Whi	
9	or it		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No If Yes, Give	,	1 □Yes 2 📉 No	Specify:		Specify:	L . L .
Š	ural"	d by	3 ⚠ Widowed 4 ☐ Divorced Year or Dates:	160 Docor	dent's Usual Occup	ation		16b. Kind of Business	hite s/Industry
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7	withii ene. <b>than</b>	ЩĆ	Elementary/Secondary (0-12) College (1-4or 5+)	Но	memaker			In Her	Own Home
ט ט	filed Hygi other ent, t	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle	, Maiden Surname)	
<u>a</u>	d be ental ked c	To B	John Rosequist			Ingrid	Ne1son		
ary	should be flied within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene. s marked other than "natural" or items 23a or 28a-f show umatic event, the Medical Examina must be notified.	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street	and Number or Rui	al Route Numb	per, City or Town, State,	Zip Code)
Ξ	alth a		Megan A. McGonigal/Granddaughte	r 45 F	ox Chase	Drive, E	lkton,	MD 21921	
e C	of He		20a. Method of Disposition 1 Burial 2 🕅 Cremation 3 🗆 Removal from State	<ol> <li>Place of Dispo cemetery, cres</li> </ol>	sition (Name of matory or other plac	e) July	Date	20c. Location - City of	r Town, State
Ĕ	Page nent ant: II ury o		4 Donation 5 Other (Specify)		s & Co., Ir	10. 12009			ester, PA
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inmportant: If team 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examine must be ruthfied at once.		21. Signature of Funeral Service Licensee	H-	Name and Addre	ss of Facility for Fune	rals. I	P.A.	
	20 E 2 3		Donal S. Huha	110	03 W. Sto	<u>ckton Str</u>	eet, E	lkton, MD	21921
			23a. Part 1. Enter the disease, or complications that caused the dishock, or heart failure. List only one cause on each line.				or respiratory	arrest,	Approximate Interval Between Onset and Death
F	Physician		Immediate Cause (Final disease or condition	Seule	AS.				
	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a constitute of the condition	sequence of):	λ	. 11.			
	LAdillilei	<u>.</u>	Sequentially list conditions, if any leading to immediate Due to (or as a cons		nce ven	cutyce			-
	ted sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	sequence on.					
	and al-trar	Examiner	that initiated events c	sequence of):					
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687	ificate g phy is the	edic							
Box	n cert anding use a	Z	IF FEMALE: 23c. If yes, outcome of pre		☐ Ectopic pregnanc			23d. Date of d	
m	death e atte d for	icia	in the past 12 months?    1   Yes   2   No   9   Unknown		Other (specify)	" N/A		Month	Day Year
Ö.	t the by th tache	Physician/Me	9 Unknown				1/4		
Division of Vital Records, P.O.	w requires that the death certifices been signed by the attending is should be detached for use as		Part II. Other significant conditions contributing to death but not	resulting in the u	ınderlying cause giv	en in Part I.		tobacco use contribute	Probably 4 ☐ Unknown
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ec ec	law n as be 2 sh	ple	Atrial Fibrillation	1			24a. Wa auto	opsy prior t	autopsy findings available completion of cause of
<u> </u>	The ate h page	Completed by	Dysphagia				per 1 □ Yes	fórmed? death 2 Mo 1 □ Y	es 2🗷 No
/ita	iician: The lav certificate has ector, page 2	Be	25. Was case referred to medical examiner?			26. Place of Dea			
£	Physi this c			2 ER/Outpatie	INT 3 DOA			sidence 6 Other (S how injury occurred	pecify)
Ĕ	ling F	<u>ö</u>	1 Natural 5 □ Pending (Month, Day, Yea	r) Injury	Wor	rk? ]Yes 2 □ No	200. Describe		
Sic	ttenc death tor: / the	icat	2 ☐ Accident investigation N/A 3 ☐ Suicide 6 ☐ Could not be 28e Place Injury - A		/+	100 100	28f. Location	N/A (Street and Number or	Rural Route Number,
<u>&gt;</u>	or A after Direc	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place 1 Injury - A building, etc. (Sp.	ecify) N/A	,		City or To	own, State)	
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a, Certifier 1. Certifying Physician: To the best of my	knowledge dea	th occurred at the t	ime, date and place	e, and due to th	ne cause(s) and manner	as stated.
	n 24 h	Medical	(Check only one)  2 Medical Examiner: On the basis of examiner and manner stated.	nination and/or i	nvestigation, in my	opinion, death occi	irred at the time	e, date and place, and d	ade to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	. 4 %	29c. Licen			29d. Date signed (Mo	onth, Day, Year)
				MD		006219		7/6	12009
			30. Name and address of person who completed cause of death	(Item 23a) (Type	, Print)	<i>(</i> )	0/	LITONI A	10 21921
			SHAHNAWAZ KHAN, 11	IW, H	16H ST;	SUITE IS	15 , E	- LINION, I	11 61 16
	St Regist	ate rar	31. Date filed (Month, Day, Year)  32. Registrar's S	igriature .	borres			LIKTON, N	

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene U 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Day Year Month **Physician** 10:50 A M 27 2009 SARAH RACHEL LEWIS June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Golden Living Center Cumberland Allegany If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🛣 F 234-38-8311 Aug. 7 1924 West Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Items 23a or 28a-f show the Medical Examiner must be notified at Yes 2 No Director MD OLDTOWN Allegany 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 18800 Picardy Trail S.E. 21555 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No
If Yes, Give
Year or Dates: within 72 hours after 1 □ Never Married 2 □ Married Specify: White Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 No Specify: ð 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filled with Department of Health and Mental Hygien importent: If Item 27 is marked other that any injury or other traumatic Homemaker Domestic 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Carrie Edna Orndoff Les Corbin 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 18800 Picardy Trail S.E. Oldtown, MD Joy Cutter Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Branch Mountain Cem. 6/30/2009 Levels West Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Kimble Funeral Home 188 Mosser Avenue Paw Paw, WV 3a. Part I. Emir the disease, or or neutrations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Metastatic Immediate Cause (Final disease or condition resulting in death) hung lancer omarten Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the ettending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? fibrillation 1XYes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 26 No 1 Yes Ø No Hospitel or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Surring Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 27. Manner of Math 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 5 Pending investigation Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Slain 7/2/09 D46346 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave. Ste. 204, Cumberland, MD 21502 Huma Shakil, 625 Kent parket Registrar's Signatule

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend#17. Per Informant PCC7-7-09cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2009 Year Month **Physician** 9:44 P M 23 JUNE G. MOORE **JOSEPH** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGE'S CHEVERLY PRINCE GEORGE'S HOSPITAL 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min. 1**X** M 2 □ F TENNESSEE 67 Director 209-32-0258 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County 10a, State 28a-f show ral", or items 23a or 28a-f shov Examiner must be coffiled at ty⊒Yes 2 □ No Director CAPITOL HEIGHTS PRINCE GEORGE'S MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20743 6701 WILBURN DRIVE Funeral death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Xes 2 ☐ No ARMY Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or itel any Injury or other traumatic event, the Medical Exami 1 Never Married 2 Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xo If Yes, Give Year or Dates: Specify Specify: ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE VERIZON TECHNICIAN 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joe Willie Moore CORA FOSTER JOSEPH G. MOORE SR. ဨ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type. Print) 6701 WILBURN DRIVE CAPITOL HEIGHTS, MARYLAND 20743 PHYLLIS MOORE/WIFE 20c. Location - City or Town, State Date 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MD VETERANS CEMETERY 7/2/2009 CHELTENHAM, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) J. B. JENKINS FUNERAL HOME 22. Name and Address of Facility 21. Signature of Funeral Service License 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** COLON CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. physician and the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 27 No 3 ☐ Probably 4 ☐ Unknown Completed RENAL FAILURE 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? certificate has t rector, page 2 s 1 ☐ Yes 2 ☑ No 1 ☐Yes 2 ☑No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2XNo 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No ours after death.
neral Director: # 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one)

10, B State

Registrar

31. Date filed (Month, Day, Y Year)

29b. Signature and title of certifier

32. Registrar's Signature ask

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANIEL R. ALEXANDER 12700 GOODLOES PROMISE DRIVE BOWIE, MARYLAND

29c. License number

D52815

29d. Date signed (Month, Day, Year)

JUNE 26, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 07/06/09, per FD, Allegany Co State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 2009 9:40pm M Shirley Thomas Miller 23 June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 13305 Old Cumberland Road Flintstone Allegany If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12/31/1933 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 5. 229-42-0561 **Funeral** 1 € M 2 □ F Months Virginia 75 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 28a-f show in than "natural", or items 23a or 28a-f shortha Medical Experience must be notified at 1 ☐ Yes 2 ☐ No Director MD Allegany Flintstone 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13305 Old Cumberland Road 21530 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ∏Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21/2 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Construction Painter 7 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental HENRY Clay Miller Evelyn Elizabeth (Young) Miller ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any Injury or other trau
once. Dorothy M. Miller / wife 13305 Old Cumberland Road, Flintstone, MD 21530 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Highland, Memory Gardehs 6/26/2009 Dublin, Va 4 ☐Donation /S ☐Other (Specify) 21. Signature Fu al Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a const guence Examiner Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consciousnce of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐ No cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 1 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 I atural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of 6/24/2009 D22181 3/2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 70 Walsh Road, Cumb., MD 21502 925 Bishop 32. Registrar's Signature State JUN 25 2009 Registrar

Amended #5, nls,

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		Registrar  1. Decedent's Name (F	irst, Middl	e, Last)						2. Date of D		Tpumb	V	3. Time o	Death
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Examin		4a. Facility Name (If no	t institutio	n, give stree	et and numbe	er)		4b. City, Town, o	r Location of Dea	ath		4c. Cou	inty of Death	1	
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Funeral Director		214-07-624		1 M	2 <b>X</b> F	97	Yrs.	Months Days	Hours Mir		Day, Y		Cot	untry) MD	or i oroign
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arylar show	۲	10a. State	b. County			10c. Cit	y, Town or Loc	ation						10d. Inside C	2 □ No
the Maryland	Director	MD 10e. Street and Number	Alle	gany_			Cumber1	and 10f. Zip Code			100	g. Citizen	of What Cou	untry?	
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permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other thar any Injury or other traumatic event, Ihe M once.		21. Signature of Funer	al Service	Licensee				. Name and Addre		Adams Fa		-		_	PA
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e Hos 124 hc e Fun letely	edical	(Check only 2[	Medical	Examiner:	On the basi and manner	s of examina	ation and/or in	vestigation, in my	opinion, death or	ccurred at the tim	ne, dat	te and pla	ice, and due	to the cause	(s)
To the Hospital or Attendin within 24 hours after death.  To the Funeral Director: Aft completely filled in by the fun	Me	29b. Signature and title	e of certifie	er	. (			29c. Licen		-	29	d. Date si	igned (Monti	h, Day, Year)	_
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Registrar DHMH 17 Rev 1/2001

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	Physic		JAMES ALBERT MYE						JUNE 2	24, 200	9 Year	4:25	A
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	Funeral		5. Social Security Number 6. Se	7. Ag		ast birthday)	If Under 1 Yea Months Day	r If Under 24 Hrs				place (State intry)	or Fore
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	h the	Funeral Director	10e. Street and Number	orge s		nple H	10f. Zip Code			10g. Citizen	of What Cou	intry?	
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	ems	Inel	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S	S. 13.	Nas Decedent of	f Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or N	o- 14. F	Race - Ameri Black, White,		
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a Medical Examinator must be redified at any pings.		1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ N If Yes, Give Year or Dates:	√o		1 □Yes 2 🗓 N		, , , , , , , , , , , , , , , , , , , ,		cify: Bla		
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	othe othe	Be C	17. Father's Name (First, Middle, Last)					18. Mother's Nar	me (First, Middle	e, Maiden Surn	ame)		
Maryland	Aenta Aenta rked tic ev	To E	Sheldon Myers					Ethelue	Zimmer	man			
ary	2 should and Mer Is marke aumatic	-	19a. Informant's Name/Relationship (7	ype. Print)		19b. Mailii	ng Address (Stre	et and Number or Ri	ural Route Num	ber, City or Tov	vn, State, Zi	ip Code)	
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ore.	of He of He roth		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of natory or other p	lace)	Date	20c. Locatio	n - City or T	own, State	
Baltimore,	permit. Pages Department of I Important: If its any Injury or or		1  Burial 2  Cremation 3 4  Donation 5  Other (Specify		1	monv	Memorial	6/30	/2009	Landov	ver. M	lary1aı	nd
alt	permit. Departr Importa any Inju		21. Signature of Funeral Service Licens	see		22	. Name and Add	lress of FacilityPop	e Funer	al Home	es, P.	A.	
	Physician /Medical Examiner	Examiner	23a. Part F. Enter the disease, or comp shock, or heart failure. List only commediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter uncertying	a. Due to (or as	a consequ	ience of):	. J	ying, such as cardia	c or respiratory	arrest,		Approxima Interval Be Onset and	etween
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	To the Hos within 24 hd To the Fun completely	Me	29b. Signature and title of certifier				29c. Lice	nse number		29d. Date sig	ned (Month	, Day, Year)	)
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Registrar
DHMH 17 Rev 1/2001

State

20622

mD

CHARLOTTE HALL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JUN 3 0 2009

L

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** June 24, Martha Barbara Mucci 8:45 a /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Holy Cross Hospital Silver Spring 9. Birthplace (State or Foreign Country) New Jersey 8. Date of Birth (Month, Day, June 28, 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 □ KF Months Days Hours Min ຶ່າ 925 149-12-2582 83 June Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, its Predical Examination must be notified at 1 ∐ Yes 2¥ No Director Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12822 Bushey Drive 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 <sup>Specify</sup>White If Yes, Give Year or Dates: 1 ☐Yes 2 XNo Specify: 3 3€XWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) tal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental Joseph DelGesso Lena Mungoli 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Michael Mucci/Son 19916 Mt. Airey Road, Brookeville, MD 20833 of Health item 27 I 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date permit. Pages Department of Important: If it any injury or o once. 29 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State June Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2009 Silver Spring, Maryland 21. Signature of Funeral Service Licensee Francis Address Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Pneumonia weeks /Medical Due to (or as a consequence of): Examiner Pleural Effusions weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Renal Failure weeks burial-tran and Due to (or as a consequence of) physician s the burial Box 68760 certificate be Physician/Medical Metastatic Breast Cancer to Bone months attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) □Yes ed by the a o 9 Unknown 9 Unknow ۵. signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 No Division of Vital Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA After this Certification: To 27. Manner of Death 1 Matural 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending (Month, Day, Year) Injury 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🕊 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 29c. License number D65485 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) **JUN 26** 

Barbara Supanich, MD

32 Registrar's Signature

1500 Forest Glen Road, Silver Spring, MD 20910

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of Ma	aryland / I	•	rtment of H fificate of L			Reg. No.	009	222	62
	Physicia	an	1. Decedent's Name (First, Midd						2. Date of Dea Month	Day	Year	3. Time of D	
Ì	/Medic	al	Clinton Nichol  4a. Facility Name (If not institution)			—Т	4h City Town or	Location of Death	June	20,	2009 ounty of Death	8:15	$\mathbf{P}^{M}$
	Examin	er	Pine View Nurs				Clinton				ince Geo	rges	
	Funeral		Social Security Number	6. Sex 7. Age	e (In yrs. last bii	rthday)	If Under 1 Year Months Days		8. Date of Birt (Month, Da	h v, Year)	9. Birthpl Coun	lace (State or .	Foreign
	Director		578-40-5452	1 🔯 M 2 🗆 F	87	Yrs.	Months Days	Tiodio IVIII.	May 1,	1922	Washi	ngton I	DC
	and ow f		Usual Residence of Decedent  10a. State 10b. Count	ty	10c. City, Tow	n or Loc	ation				10	Od. Inside City	Limits
	Mary I sh	tor	DC		Washin	gton						1XX Yes 2	2 □ No
	th the	Director	10e. Street and Number				10f. Zip Code				n of What Count	-	
	ath wi		3363 Denver St				2002				ed State		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be neutriced at once.	by Funeral	11. Marital Status  1 ☐ Never Married 2 【※Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes, Give			as Decedent of Hi Yes, specify Cuba □Yes 2 🍇 No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	Decity Yes or No Di Rican, etc.)		. Race - America Black, White, e Afri pecify: Amer	etc.	
2	72 ho 'natur	eted	15. Decede (Specify only high	ent's Education nest grade completed)	16a	. Decede	ent's Usual Occupa	ation during most of work l)	king	16b. Kind	of Business/Ind	lustry	
21	within ene. <b>than</b> "	Completed	Elementary/Secondary (0-12)		+) E.(		O NOT use retired tion Per:		l l	DC Pu	blic SC	hoo1	
d 2	filed v Hygie other ent, the	Be Co	17. Father's Name (First, Middle					18. Mother's Nam					
<u>la</u> n	Mental Mental rked o	To B	Robert Nichol	las Mattingly				Mary Bal	ltimore				
lar)	2 short and 1 is ma		19a. Informant's Name/Relation		I .			and Number or Ru					
ა ე	1 and tealth sm 27 ther tr		Julie Matting 20a, Method of Disposition	sly / Wife				treet, SI	Date Washi		tion - City or To	20020 wn. State	
nor L	ages int of h		1 ☑ Burial 2 ☐ Cremation	3 Removal from State			ition <i>(Name of</i> atory or other plac Memorial	1 . 10.	/2009		and, MD		
altimore,	artme ortan injury		4 □ Donation 5 □ Other (		Line			ss of Facility Mc					
ñ	Per any any any any		· Calerie	1. Olwer	/	1.		ia Avenu					
			23a. Part 1. Enter the disease, shock, or heart failure. Lis	or complications that caused st only one cause on each lir	I the death. Do ne.	not ente	r the mode of dyin	ıg, such as cardiac	or respiratory a	rrest,		Approximate Interval Betw Onset and De	een eath
	Physician		Immediate Cause (Final disease or condition resulting in death)	a			se, adva	nced					
1	/Medical Examiner		rooming in deality	Due to (or as	a consequence	of):							
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence	of):							
2	ecuted ind transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с									
90,	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as	a consequence	of):							
68760,	ificate be executed g physician and ss the burial-transit	edical		d									
O. Box	ath cert attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant a 9  Unknown	2 Fetal deat		Ectopic pregnanc Other (specify)	у		23	d. Date of delive Month	-	ear
ds, P.	ires that the de signed by the a d be detached to	þ	Part II. Other significant condi	tions contributing to death b	ut not resulting	in the un	derlying cause give	en in Part I.			e contribute to the		
Ö	w requir been s should	Completed	Poor oral int	take					24a. Was	an	24b. Were auto	psv findings a	vailable
æ	<u>о</u> <u>т</u> о	dmc							auto		prior to co death? 1 ∐Yes	mpletion of ca	use of
<u>ta</u>	sician: The certificate h rector, page	Be C	Hypertension 25. Was case referred to medic	cal				26. Place of Dea			i Lites	2 🗆 140	
<u>&gt;</u>	Physic this ce al direc		examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpatie	ent 2 ER/O			4 EM Nursing H	lome 5 ☐ Resi			fy)	
S C	ding Ph h. After th funeral	ion:	27. Manner of Death 1 Natural 5 ☐ Pend	28a. Date of Inju		Time of Injury	28c. Injur Worl		28d. Describe	how injury o	occurred		
Division of Vital Records,	Attending Physician: Ir death. ector: After this certific. by the funeral director.	ficat	3 ☐ Suicide 6 ☐ Could	Zoe, Place of Info	urv - At home, f	arm, stre		Yes 2□No	28f. Location (	Street and	Number or Rura	ai Route Numb	ber,
<u>&gt;</u>	2 4 5 5	Certification: To	4 ☐ Hornicide deter	rmined building, et	c. (Specify)		, <b>,</b> ,		City or To	wn, State)			
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Medical (	29a. Certifier 1 Certify (Check only one) 2 Medica	ying Physician: To the best al Examiner: On the basis o and manner st	f examination a	ge, death ind/or inv	occurred at the til estigation, in my o	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) a date and p	and manner as solace, and due to	stated. o the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certif	iter			29c. Licens				signed (Month,		
	10		•   ///w/(				D 5	1520		06-	25-201		
			30. Name and address of person Dr. Bahram Pis	•				Jachinoto	n DC	20032			
	Sta	te	31. Date filed (Month, Day, Yea	ar) 37. Registr	ar's Signature			vasiiTiigu	טע נווי	20032			
	Registr		JUN 26	2000 /2	. 1	bar	Ked						

DHMH 17 Rev 1/2001

			For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of I rtificate of			giene Reg. No. 2	119	22263
		17	Decedent's Name (First, Middle	e, Last)		·		2. Date of De	ath	Year	3. Time of Death
	Physici /Medic		Francis Eugen	e Moyers				June	24, 200	9	6:10 P <sup>M</sup>
4	Examir		4a. Facility Name (If not institution	n, give street and number	-)	4b. City, Town,	or Location of De		4c. County	of Death	
			Wilson Health			Gaithers			Montg		
ı	Funeral Director		5. Social Security Number 214–32–9726	6. Sex 7. A	ige (In yrs. last birthday) 74 Yrs.	Months Days	If Under 24 H Hours Mi	n. (Month, Da	y, <sub>Year)</sub> ), 1935	Coun	ace (State or Foreign try) Land
	w .		Usual Residence of Decedent  10a. State 10b. County	,	10c. City, Town or L	ocation				1	0d. Inside City Limits
	Maryla f sho led at	5	Monto		Cormantor						1 □Yes 2 No
	the 128a-	rect	MD Monto	omery	Germantow	10f. Zip Code			10g. Citizen of	What Coun	try?
	n with		19200 Circle G	ate Drive #	103	20874			USA		
	deat	ner	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S. 13.		Hispanic Origin?	(Specify Yes or No erto Rican, etc.)	- 14. Rac	ce - Americ	
9	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Examiner must be notifled at	by Funeral Director	1 Never Married 2 XMar	ried 1 Yes 2	] No	1 ☐ Yes 2 🛣 No		,	Specif	he	
8	72 hours "natural"; dical Exa	q p	3 ☐ Widowed 4 ☐ Divorced		1953–57	edent's Usual Occu	nation		16b. Kind of B	MIIT	
15	n 72   "nat edica	lete	(Specify only highe	nt's Education est grade completed)	(Give	e kind of work done  DO NOT use retire	during most of ved)	vorking	100. Killa of B	usiness/in	lustry
21215-0036	should be filed within of Mental Hygiene marked other than "matic event, the Med	Completed	Elementary/Secondary (0-12)	College (1-4or	r 5+)	trician :	_		Electr	ric	
	e filed Il Hygi other /ent, tl	e C	17. Father's Name (First, Middle,	, Last)				lame (First, Middle			
<u>lar</u>	ould be a Mental larked or	To Be	Benjamin Frank	lin Moyers			Missou	ri Alice	Burkett	:	
Maryland		ľ	19a. Informant's Name/Relations			•		Rural Route Numb			*
	and ealth m 27		Lisa L. Moyers	s/Daughter/Pl				. #103 G			
Baltimore,	permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau		20a. Method of Disposition  1 Darial 2 Coremation	3 ☐ Removal from Stat	e 20b. Place of Disp cemetery, cre				20c. Location	-	
ţ	rtmer rtmer rtant: njury		4 ☐ Donation 5 ☐ Other (3					06/25/09			
Ba	permit. Departr Importa any inju		21. Signature of Furieral Service	£4.11.4				ion Servi			x 784 e, MD 21029
	1 1000		23a. Part1. Enter the dis the, o	r complications that cause	ed the death. Do not er					, , , , , ,	Approximate Interval Between
	Physician		shock, or heart failure. Lis Immediate Cause (Final	t only one cause on each	line.	- 1000	+0	= \			Onset and Death
$L_{i}$	/Medical		disease or condition resulting in death)	a. Due to (or a	is a consequence of):	e vee	m (	on lave		-	
8	Examiner		Conventially list conditions	h	hu so to	V912N	0				
	₽ ##	iner	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	is a consequence of):		1 0				
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to /or a	as a consequence of):	ue Ver	al Ol	iseanc	_		
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387	icate physi	dical		d	avanen	3 10000 A	<b>S</b>				
Box (	death certifi e attending p d for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom					23d. D.	ate of deliv	ery
m	death atter	iciai	in the past 12 months?	4□Pregnant	at time of death 5	□Ectopic pregnan □ Other (specify)	cy		M	lonth	Day Year
P.0	that the de ned by the a detached t	hys	9 Unknown	9□Unknown							
	The law requires that the site has been signed by the bage 2 should be detached.	y P	Part II. Other significant condit	ions contributing to death	but not resulting in the	underlying cause g	iven in Part I.				he cause of death?
Records,	equire en sig	Completed by						_ 10	Yes 2 No	3 ☐ Prof	oably 4 Unknown
ec C	e law r has be je 2 sh	ple						24a. Was	psy	prior to co	psy findings available mpletion of cause of
	The	Sol						perf 1☐ Yes	ormed? 2 X No	death? 1 ☐ Yes	2 No
Vita	s <b>ician</b> : Th certificate rector, pag	Be	25. Was case referred to medici examiner?	Hospital:			hor: 1 d	Death (Check only			
or Vital	Physician: this certific	2	1 ☐ Yes 2 No 27. Manner of Death	1 □ Inpa		ent 3 DOA	4 L Nursin	g Home 5 ☐ Res	idence 6 001 how injury occu		fy)
on	ding F h. After funera	tion	1 XNatural 5 ☐ Pendi		Day Year) Injury	W	ork? ∐Yes 2∐No	200. Describe	now injury cooc		
Division	Attending r death. ector: After by the fune	fica	3 Suicide 6 Could	not be 28e. Place of i	njury - At home, farm, s			28f. Location	Street and Num	ber or Run	al Route Number,
Ö	al or after	Certification:	4 Homicide	building,	etc. (Specify)			City or 10	wn, State)		
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	calC		ing Physician: To the best							
	the H in 24 the Fi	Medical	one)	and manner							
	To the within To the comple	2	29b. Signature and title of certifi	er	\	N	ise number		29d. Date sign	ed (Month,	Day, Year)
"			* XXX	M	7		05757	4	6	2	<b>W1</b>
(	5 /2 -		30. Name and address of person	n who completed cause of	f death (Item 23a) (Type	, Print)	N 2	N	. \	TIM	20055

Registrar
DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . Day 2009 Year Month **Physician** 24,  $p^{M}$ June 7:40 Olga Mladushnik /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ivy Manor Chestnut Ellicott Howa 5. Social Security Number If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 05/25/1918 6. Sex 7. Age (In yrs. last birthday, Country) 1 □ M 2 X 151-07-0267 91 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No Director Bethesda Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20816 United States 4704 River Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify Specify: ģ 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed Food Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Diana Dziubinska ည Michael Barna 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bethesda, MD 20815 4704 River Road Diane Monash - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☑ Cremation 26/09 Ardent Crematory Hanover, Maryland 4 □ Donation 5 Other (Specify) f Fun II S 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 21. Signatur M00845 21043 4112 Old Columbia Pike Ellicott City, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of a cardiac or respiratory arrest. Immediate Cause (Final disease or condition resulting in death) for as a consequence of) lom Sequentially list conditions. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If ves. outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe /es 2 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident (Month, Day Year) Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Examiner the death certificate be executed Division or Vital Records, P.O. Box 68760,

burial-transit and attending physician the as use for ned by the a cate has been signed by page 2 should be detact certificate

**Funeral** 

Director

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

filed within 72 hours after

permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygic Important: If Item 27 Is marked other any Injury or other traumatic event, the

**Physician** 

/Medical

Baltimore, Maryland 21215-0036

The law requires that thin 24 hours after death.

thin 24 hours after death.

o the Funeral Director; After this certifica

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			D.	

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation in manner as data. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and thie of c

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and add

Linthicum, MD21090

31. Date filed (Month, Day, Year) **JUN 26** 

3 ☐ Suicide

29a. Certifier

Medical

State

istrar

4 Homicide

(Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 632 M Mª DONULGH **Physician** GERALD 1 HUMAS 00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's 16313 Bawtry Court Bowie. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Year) Days 1**Z**M 2□ F Vrs 220-34-4251 93 28,1915 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County ? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinal must be indiffed at 1X Yes 2 □ No Director MD Prince George's Bowie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 16313 Bawtry Court 20715 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 14. Race - American Indian, Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1942–45 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify Specify. þ 3 □ Widowed 4 □ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. Elementary/Secondary (0-12) 12 n and Mental Hygiene. College (1-4or 5+) Personnel Administration U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ellen Teaque John McDonough ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2:
Department of Health ar
Important: If item 27 is
any Injury or other trau Ann McDonough / daughter 16313 Bawtry Court Bowie, MD 20715 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Annapolis Nat'l Cem. 6/24/2009 Annapolis, MD 22. Name and Address of Facility Beall Funeral Home e of Funeral Service 6512 NW Crain Hwy. Bowie, MD 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final can **Physician** disease or condition resulting in death) /Medical Due to or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last death certificate be executed ending physician and use as the burial-transi Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day for in the past 12 months? Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 1 ☐Yes 2 ☐No 9 HInknown 9 Unknown signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy perform 1 ☐Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural
2 Accident 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Date filed (Month, Day, Year)

3. Registrar's Signature

State Registrar

4+10

31. Date filed (Month, Day, Year)

**Physician** /Medical Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examinar must be retified at any injury or other traumatic event, I'm Medical Examinar must be retified at any injury or other traumatic event, I'm Medical Examinar must be retified at any injury or other traumatic event, I'm Medical Examinar must be approximated.

1	For State Registrar						Cer	tificate o	f Deatl	h		Reg.	No. 2 [	100	2	2266
-	1. Decedent's Nam										2. Date of Month		Day,	Year	3. Tin	ne of Death
_	CARROLL				- 4 - 1					10.11	JUN.	E		2000		I'I FM
4	la. Facility Name (			reet and nu . CEN	-			4b. City, Town	, or Location LATA	n of Death			4c. County	ARLL		
5	5. Social Security N		6. Sex	. 02.1			st birthday)	If Under 1 Yea	ar If Unde	er 24 Hrs.	8. Date of	Birth		9. Birt	hplace (St	ate or Foreign
	219-12-36	670	11	M 2□F		84	Yrs.	Months Day	/s Hours	Min.	8. Date of (Month) JUNE	28,	1924	MĂĨ	RYLAN	D
	Usual Residence o	f Decedent 10b. Coun	tv		1	Oc City	Town or Loc	ration							10d. Insid	de City Limits
	MD	CHAR	•				BURG	Sation								Yes 2 □ No
	10e. Street and Nu 12418 CI	ımber		DRIV	E			10f. Zip Code 20664				-	. Citizen of		-	
	11. Marital Status 1 ☐ Never Marr 3 ☐ Widowed	ried a Ma	12 arried	2. Was Dece Armed Fo 1/12 Yes If Yes, Gi Year or D	orces? 2  No ive	er in U.S.	Į.	Vas Decedent of Yes, specify C	uban, Mexic	can, Puerto	pecify Yes o Rican, etc.	No-		ack, White	erican India e, etc.	in,
	Elementary/Seco	cify only high		ation completed) College (1	1-4or 5+)	-	(Give life. L	lent's Usual Occ kind of work dor DO NOT use reti	ne during m	ost of work	king		b. Kind of B  EDERA		_	ENT
	10 17. Father's Name IRVIN M						PAIN	I CK			e (First, Mic	idle, Mai			A EVIAL.	IBN 1
	19a. informant's N			e. Print)				g Address (Stre				,	*	n, State, 2		
	20a. Method of Dis		***************************************			20b. Pla	ice of Dispos	sition (Name of			Date		c. Location	- City or	Town, Sta	te
	1 ABurial 2 4 Donation			moval from			•	iatory or other p	nace)						100	
						MD V	FTERA	NS CEME	TERY :	. 07/	06/200	ე9 (:	негле	NHAM	MI)	
	21. Signature on Fi	uneral Service	conse	א נוש וני	Code	MD V	ETERA	NS CEME	dropp of Eng	nilibe	06/200		HELTE	NHAM	, MD	
	LYDIA	C. TH	IORNTO	N JOH	NSON	-	T 3	Name and Ad HORNTON 439 LIV	ress of Fac FUNEI INGST	RAL H ON RO	OME, I	P.A. NDIA	N HEA		rest in the	40
	age	C. The the disease, art failure. L	ORNTO or complication	ations that decause on e	INSON caused the	ne death.	Do not ente	Name and Ad HORNTON 439 LIV	ress of Fac FUNEI INGST	RAL H ON RO	OME, I	P.A. NDIA	N HEA		D 206	
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BB481

State Registrar

ABBAS A. OHAIS, 31. Date filed (Month, Day, Year)

JUN 26 2009

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. CENNA MEDICAL CENTER 7-C POST OFFICE RD, WALDORF, MD 20602

Physician/ Medical Examiner

#### Plea

Logan Francis Miller 1- For State Registrar 1. Decedent's Name (

Please Type or Print in Black Indelible I State of Maryland / Department of	ole.			
For State Certificate C	lo. 200	9 2226		
Decedent's Name (First, Middle,Last)		2. Date of Death	Suite Marie	3. Time of Death
LOGAN FRANCIS MILLER		Month Da June 20, 200		0806 hrs
. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	1
628 Main Street	Church Hill		Queen Anne's	3

		4a. Facility Name ( 628 Main S		i, give stree	et and numb	oer)			. City, Tow <b>Church</b> l		cation of De	eath			ounty of Dea een Anne		
Funeral		5. Social Security	Number	6. Sex	7.	Age (In yrs.	last birth	day)	If Under 1	_	If Under 24		te of Birth	(MM/DD		Birthpla eign	ace (State or
Director		532-94-9		1 X M	2_F	3	2	Yrs.	Months	Days	Hours I	Min. 4/	/1/19	77			y) MT
any		Usual Residence of 10a. State	of Decedent 10b. County			10c. City	, Town o	r Location	1						-	100	d. Inside City Limits
ž ,,	_	MD	OUEEN	ANNI	E'S			HILL								1	X Yes 2 No
farylar 28a-f s I at on	Director	10e. Street and Nu		-		l			10f. Zip Co	de			100	g. Citizer	of What Co	ountry?	}
with the Maryland ms 23a or 28a-f show be notified at once.		628 MAI	N ST.						2162	3				US	SA		
th with lems 2 at be n	Funeral	11. Marital Status  1 XNever Marri	ied 2 Ma		Was Deced Armed Forc	ent Ever in U es?	J.S.				nic Origin? /lexican, Pue			14	l. Race - Am White, etc		Indian, Black,
ter death ", or iter er must		3 Widowed		1 If Yes	Yes , Give Year	2 X No		1 Y	es 2 X	No s	specify:			Sc	ecify: WH	TTE	3
ours af atural camin	d by	15. Decedent's E		or Da	tes:	completed)		ecedent's	Usual Occ	cupation	(Give kind		ie		d of Busines		
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she natte event, the Medical Examiner must be notified at once	Completed	Elementary/Sec	ondary (0-12)		College (1-4	or 5+)		•		-	O NOT use	retirea)					
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Media	mo	12 17. Father's Name	(First, Middle,	Last)	1		BR	.1CK I	MASON		.Mother's Na	ame (First, I	vliddle. M		SONRY		
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2121 hould be find Mental is marked affic event,	٥	19a. Informant's Na		nip (Type, F	Print )	-	19b	. Mailing A	Address (	Street a	nd Number	or Rural Ro	ute Numb	er, City	or Town, St	ate, Zip	Code)
조유도 2 팀		SUSAN M		10THE	3	206			W. E			CT. N	IINE		E FALI cation - City		WA 99026
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygene. ant: If item 27 is marked other than "natural"; or other traumatic event, the Medical Examiner		1 Burial 2		3 X R	emoval from	State	cremato	ry or other	r place)						·		
Baltimore, permit. Pages I an Department of Hea Important: If iten injury or other tra		4 Donation 5 21. Signature of Fu				HU.	LY C		CEME			/30/2			OKANE,		
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Physician /Medical		<ol> <li>Part I. Enter the failure. List or</li> </ol>	he disease, or only one cause of	complication	ns that cause.	sed the death	n. Do not	enter the	mode of d	ying, su	ich as cardia	ac or respira	tory arres	st, shock	, or heart		Approximate Interval Between Onset and
Fxaminer		Immediate Cause or condition resulti		a. Hang		onsequence o	- 5).									4	Death
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Rec The la icate his	Com											1 [	_ perform Yes 2		death 1	? Yes	2 No
1 of Vital Records, ting Physician: The law requir After this certificate has been si funeral director, page 2 should t	Be	25. Was case reference examiner?	rred to medical	Hospita	al: , 🖂 .		] == .a			10	Death (Che						
of Viting Physical After this uneral direction	٠ <u>۲</u>	1 ✓ Yes 27. Manner of Dea	2 No th		8a Date of	atient 2		tpatient ime of Inju			at Work?	rsing Home 28d. D			ce 6 🗸 Ot	her: So	ene
OD C ending ath. or: Af	tion	1 Natural	5 Pend	ing	FOUND: D Jun 20, 20	ay,Year)	FOU!		1	Yes	s 2 🗸 No	Subje	ct hang	ed sel	lf.		
Division tal or Attendir is after death.  al Director: A led in by the fu	Certification:	2 Accident 3 ✓ Suicide	6 Could	not be		of Injury - At h			factory, of	fice buil	ding, etc.		cation (St		Number or	Rural	Route Number, City
D ospital hours a meral y filled		4 Homicide 29a. Certifier		_		Single Far						628 M	ain Stree	et, Chur	ch Hill, ME		
Division of Vital Records, P. To the Hospital or Attending Physician: The law requires th within 24 hours after death.  To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be de	Medical	(Check only one) 2	Certifying Ph Medical Exan	niner:On th	ne basis of	examination a											ause(s)
To cor	Me	29b. Signature and	title of certifier		manner stat	<u>ed.</u>			29c. Li	icense r	number	-		29d. Da	ate signed (	Month,	Day, Year)
		0-	-~	IV	ws.				0	C.M.	Ε.			June	20, 2009		
5		30. Name and add						444 5	Porn Ct	oct D	Paltimora	MD 242	001				
	ate	Donna M. \ 31. Date filed (Mon				dical Exa				cel, D	Baltimore	, IVID Z 12	.01				
Regis		31. Date filed (Mon	JUN 2	5 2009		account.	ß.	Apa									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2009 **Physician** Harry Edwin Musser June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Seaford 5863 Eldorado-Sharptown Road Dorchester Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 € M 2 □ F 78 10/07/1930 Pottsville, PA 164-26-2750 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examirer must be notified at 1 ☐ Yes 2 🛣 No Director DE Dorchester Seaford the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1 and 2 should be filed within 72 hours after death with 1 Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or ; 5863 Eldorado-Sharptown Road 19973 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) traumatic event, It a Madical Elementary/Secondary (0-12) College (1-4or 5+) Salesman Hardware 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Kilgore Arthur Musser 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any Injury or other trau Seaford, DE 19973 Patricia Ann Musser /Wife 5863 Eldorado-Sharptown Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Crematory of Delmarva 06-29-2009 Delmar, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Short Funeral Home 13 E. Grove St, Delmar, DE 19940 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on engine. Approximate Interval Between Onset and Death 3 + 44 4000 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner puzz Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine requires that the death certificate be executed and trar resulting in death) Last Due to (or as a consequence of) burial Box 68760, physician Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy for Month Day Year in the past 12 months? 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No o 9 D Unknown 9 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 No 3 Probably 4 Unknown 1 🗌 Yes page 2 should Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? 1 □Yes 2 □No certificate 1 ☐ Yes 2 ☐ No Division of Vital the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 ☐ Other (Specify) Certification: To After this 28d. Describe how injury occurred To the Hospital or Attending Pi within 24 hours after death.

To the Funeral Director: After the completely filled in by the funera 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 > Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 32. Registrar's Signature

547-1= RIVERSIDE DRIVE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- StateAmended item#24a, WCHD, SLU, 6.29 Cortificate of Death

Reg. No. Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 7:00 PM Physician DORIS MORRIS 2009 06 26 /Medical 4c. County of Death
Baltimore Cit 4a. Facility Name (If not Institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore FUTURECARE - Homewood If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** Year) 1 □ M 2 🛣 F Yrs. 10-1-1922 86 VA Director 229-28-2692 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show dieal Examiner must be notified at 1 Nes 2 No Completed by Funeral Director Baltimore MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 2546 Cecil Avenue 21218 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify Specify: Black 3 ₩idowed 4 Divorced A snown was the same of the sa 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private School Kitchen Aide 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Joseph Young Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once. 5521 Dogwood Ave, Baltimore, MD 21207 William Gill 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition -02-2009 1 Dourial 2 □ Cremation 3 □ Removal from State Angel Visit Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Dunnsville, VA 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 917 W. Isabella St Bennie Smith 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Salisbury, MD 21801 Approximate Interval Between Onset and Death Immediate Cause (Final Allon solution to the total and the total an **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed and Due to (or as a consequence of): physician a s the burial-1 Box 68760, Physician/Medical as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 5 ☐ Other (specify) 4□Pregnant at time of death P.O. ed by the a detached f 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsv nerform 1 ☐ Yes 2 ☐ No certificate uneral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA P To the Hospital or Attending Phys within 24 hours a "er death".

To the Funeral Director: After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier 30. Name and address of person who mpleted cause of death (Item 23a) (Type, Print) 1600 W. MOUNT Royal Are Balte 21217 SALUJA DARSHAW. S

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 2215 PM 2009 Henry Waddell McNeil 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WIOMICO 14136414 POICAZ If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1**X** M 2 □ F Feb. 1929 North Carolina Director 246-205672 80 21. Usual Residence of Decedent 10d. Inside City Limits 10a State 10b County 10c. City, Town or Location 28a-f show other traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 ☐ Yes 2XXNo Maryland Wicomico Salisbury 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other incompany or other incompany or other incompany or other incompany. USA 1103 Tuscola Avenue 21801 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 □ Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Wicomico County Board Elementary/Secondary (0-12) College (1-4or 5+) of Education maintenance worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bessie Montague Larion Augusta McNeil 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patsy McNeil/wife 1103 Tuscola Avenue, Salisbury, Maryland 21801 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State Singing Union Cemete. 07/05/2009 5 Other (Specify) Tabor City, N. C. 4 Dopation 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD ure of Funeral Ser MEMORIAL CHAPEL IOLLEYApproximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy signed by the at d be detached for 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown neec 24b. Were autopsy findings available prior to completion of cause of death? page 2 s this certificate has autopsy performe 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b Time of 28d. Describe how injury occurred After 5 Pending investigation Division 1 Natural ours after death.

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filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital
within 24 hours a
To the Funeral C 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTERN SHORE DA, 31. Date filed (M Year State Registrar

	•	State Registrar			Cer	tificate of l	Death		Reg. No.	2003	66611
Dhuaiaic		1. Decedent's Name (First, Middle, Las						2. Date of Month	Death Day	Year	3. Time of Death
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Examin		4a. Facility Name (If not institution, give	,			4b. City, Town, or			4c. 0	County of Death	.4.4.
/		Peninsula Regiona		Cer			10/15/64	/	Dist		
Funeral Director		5. Social Security Number  6. S  222-12-4508  Usual Residence of Decedent		(In yrs. last t	Yrs.	If Under 1 Year Months Days		Alin. 12 - 2	Day, Year) 20-19]	L6 Mai	place (State or Foreign ntry) Cyland
/land low		10a. State 10b. County		10c. City, To	wn or Loc	ation					10d. Inside City Limits
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with the Maryland a or 28a-f show	)ire	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Cou	ntry?
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ter deat	Funeral Director	11. Marital Status	12. Was Decedent Ev Armed Forces?	$194^{\circ}2$	13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin an, Mexican, P	? (Specify Yes or uerto Rican, etc.)	No- 1	<ol> <li>Race - Ameri Black, White,</li> </ol>	
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and dealth		Paula Jernigan	,daughter			earring	ton P	ost, Pi		oro, No	
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permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evence.		21. Signature of Funeral Service Licen	Mars			Name and Addre				10072	
		John A. Crai	NSTON  plications that caused t	he death. D	o not ente			Seaforo rdiac or respirator		19973	Approximate
Dhysisian		shock, or heart failure. List only immediate Cause (Final	one cause on each line								Interval Between Onset and Death
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w requires t s been signe should be	Completed							24a. V	/as an	24b. Were aut	opsy findings available
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ysicl is cer direct	To B	examiner? 1 <b>⊠</b> Yes 2 ☐ No	Hospital:	t 2 ER/	Outpatier	t 3 DOA Oth	or:	ng Home 5 ☐ F		☐Other (Spec	eify)
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or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	building, etc.	y - At home, (Specify)	farm, str	eet, factory, office	S	City or	Town, State)		ral Route Number,
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State of Maryland / Department of Health and Mental Hygiene

09-05279 Daniel Phillip Milam

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 22272

		1- For State Registrar	Cer	tificate o	f Death			Reg	J. No.		
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		4a. Facility Name (if not institution, g			4b. City, To	wn, or Lo	cation of Dea	th	4c. County of	Death	
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Funeral		Social Security Number 6.	Sex 7. Age (In yrs. Ia	ast birthday)	If Under	1 Year	If Under 24H	rs. 8. Date of Birth	(MM/DD/YYYY)	9. Birthplace (State or DC	
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5-0 ed w Hygie othe	Ŝ	17. Father's Name (First, Middle, La	· ·			18	3.Mother's Nar	ne (First, Middle, M	laiden Surname)		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Abner Giles M	Milam, III				Susan	Y. Steel	.e		
21 Suld Juld Juld Juld Juld Juld Jule ev	မ	19a. Informant's Name/Relationship	(Type, Print )	19b. Maili	ng Address	(Street	and Number o	r Rural Route Num	ber, City or Town,	, State, Zip Code)	
MD td 2 sho tlth and m 27 is aumati		Susan Vasquez (m	other)	P. 0	). Box	202	, Nanje	emoy, MD	20662		
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once	4	20a. Method of Disposition	20b.	Place of Dispo	osition (Nam	e of ceme	etery,	Date	20c. Location - 0	City or Town, State	
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Baltimore, permit. Pages I ar Department of Hee important: If ite		4 Donation 5 Other Special Signature of Funeral Service Lice	ensee MOISSS	surrect	Name and	Ceme Address o	tery	Funeral	Homo I	n, MD Inc 6633 Old	
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Division tal or Attendii rs after death.	Certification:	3 Suicide 6 Could n 4 Homicide determi		e				or Town, S	arlboro,	wneeling ave	
Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial—trans		29a. Certifier	sician: To the best of my knowled	ige, death oor	curred at the	time, dat	te and place a				
To the I within 2. To the F complete	jca	one) 2 Medical Exami	ner:On the basis of examination a	and/or investi	gation, in my	opinion,	death occurre	ed at the time, date	and place, and du	ue to the cause(s)	
To To	Medical	29b. Signature and title of certifier	and manner stated.		290	. License	number	-	29d. Date signe	ed (Month, Day, Year)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-05187 State of Maryland / Department of Health and Mental Hygiene Nathan Benjamin Neely Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day July 1, 2009 1143 hrs Neelv Benjamin Medical Examiner Nathan 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Glen Burnie Anne Arunde Baltimore Washington Medical Center 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign Wash . D. C. If Under 24Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Days Hours 10/23/1977 Director Country) 220-17-6568 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Yes 2 X No or items 23a or 28a-f show must be notified at once. Whittier Californi**a** Los Angeles Pages 1 and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 90605 USA 11915 Carmenita Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married 2 X No Yes Specify: Black Yes 2 X No specify: If Yes, Give Year 4 Divorced Widowed ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than ' MD 21215-0036 Internet Business Self-employed 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Angelet Mims Roger H. Neely, Sr. Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Renee M. Neely-Walters/Sister 12120 Wallace Lane Upper Marlboro, MD. 20772 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 7/11/2009 Waldorf,MD. permit. Pages Department o Important: Heritage Mem'l Cem. Other Specify Donation 5 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service License 6160 Oxon Hill Rd. Oxon Hill, MD. 20745 Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Medical Death Atherosclerotic cardiovascula disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) Cause, Linter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and 23a,P11,27,perME, g893 7.20.09 TT Physician/Medical attending physician a for use as the burial X UNPENDED AMENDED Box 68760. 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE 23b. Was decedent pregnant in the Year Live birth Ectopic pregnancy Fetal death 2 past 12 months' Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown 9 Unknown signed by the a be detached for 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ģ 1 Yes 2 ✔ No 3 Probably 4 Unknown σ. Ethanol, oxycodone, and diazepam use Completed Records, s been s 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy this certificate has performed? death? page 2 ✓ Yes 2 No 1 V Yes No 26.Place of Death (Check only one To the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be Other<sub>4</sub> Hospital: 1 Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 1 Yes No After the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Yes 2 No Pending To the Funeral Director: completely filled in by the Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) determined (Specify) Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title July 2, 2009 O.C.M.E. s of person who completed cause of death (Item 23a) 30. Name and addre OCME Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 Mary G. Ripple MD. State Registra

**ORIGINAL** 

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For Stete Registrar	State of	Marylan		artment of H		F	Reg. No.	09	22274
I	Physici		Decedent's Name (First, Middle	<sub>a Last)</sub> Chaim Yech	eskel	NICOLS	NC		2. Date of Dea Month	Day	2009	3. Time of Death 19.06 ρ. Μ
7	/Medic Examin		4a. Facility Name (If not institution Shady Grove Adv	o, give street and numb entist Hos	pital		Ab. City, Town, or Rockvill	l ocation of Death	1	4c. Count	y of Death ntgom	
	Funeral Director		5. Social Security Number NONE	6. Sex 7 1X M 2 F	Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birt (Month, Da)	y, Year)	9. Birth Cou Mary	place (State or Foreign http:// land
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23s or 28a-f show any injury or other traumatic event, the Macicial Examinations the notified at ances.	ector	Usual Residence of Decedent  10a. State 10b. County  Maryland Montg  10e. Street and Number	omery	10c. Cit	y, Town or Lo Chevy	Chase			10g. Citizen of		10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	23a or	Funeral Director	4708 Merivale R					20815		United	Stat	tes
9036	ours after de rai', or iteme Exeminer m	۵	11. Marital Status  1   Never Married 2   Marr  3 □ Widowed 4 □ Divorced	If Yes, Give	es? <b>⋈</b> No		Was Decedent of Hi f Yes, specify Cubar I ☐ Yes 2X No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Speci	ick, White	can Indian, , etc. nite
21215-0036	ed within 72 h giene. er than "natu	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)		for 5+)	(Give	fent's Usual Occupa kind of work done d DO NOT use retired, NONE	ation Juring most of wor )	king	16b. Kind of E	ne	ndustry
Maryland	uld be file Aental Hy rked oth tic event	To Be (	17. Father's Name (First, Middle,	David	Nicol				r Yeches	skel	-	
Mary	nd 2 sho sith and N 27 is ma r trauma		19a. Informant's Name/Relations David Nicolson,			19b. Mailir 4708	g Address (Street a Merivale	Road, Ch	ral Route Number nevy Cha	se, City or Town se, MD	208.	Code) 15
Baltimore,	Pages 1 a nent of Hec int: If Item iry or othe		20a. Method of Disposition  1 Darial 2 Cremation 4 Donation 5 Other (S)		ate Juc	Place of Disponentery, cremetery, cremetery	sition (Name of natory or other place morial Ga	ardens 06	Date 5/24/09	01 ney		own, State
Balti	permit. Departm Importa any inju		21. Signature of Funetal Service	Licensee	<u>M0</u> 100	8 TC	rchinsky 4 Carroll	Hebrew I	uneral	Home ngton,	DC :	20012
	Physician		23a. Part: Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on each	ch line.	h. Do not ent	er the mode of dying	g, such as cardiad				Approximate Interval Between Onset and Death
*	/Medical Examiner		resulting in death)		r as a conseq	uence of):	EMATUR	7				
8760,	cate be executed oblysicien and the burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	<b>S</b> c	r as a conseq r as a conseq							
P.O. Box 68	The law requires that the death certificate be executed are hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 ∏ Feta ntat time of d	Ideath 3	Ectopic pregnancy Other (specify)				ate of delivionth	very Day Year
	quires that in signed b uld be deta	ک	Part II. Other significant condition	ons contributing to dea	th but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	U		the cause of death?
Il Records,	Physician: The law requir this certificete has been si al director, page 2 should	Completed							24a. Was autop perfo 1 \( \text{Yes} \)	an 24b. osy rmed? 2 No	Were aut prior to co death? 1 \( \text{Yes} \)	opsy findings available ompletion of cause of
Vital	Physician: Th this certificete ral director, pag	) Be	25. Was case referred to medical examiner?		patient 2		. 3 DOA Othe	or	th (Check only o			
of	Attending Phyer death.  cotor: After this by the funeral di	ation: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	g 28a. Date of (Month)		ER/Outpatier 28b. Time of Injury	28c. Injury Work	4 🗆 Nursing F	lome 5 Resident			rty)
Division	al or Atte s after des il Directo ad in by th	Certification:	3 ☐ Suicide 6 ☐ Could i 4 ☐ Homicide determ	ined 288. Place 0	f Injury - At ho g, etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (S City or Tov	Street and Num vn, State)	ber or Rui	ral Route Number,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical (	29a. Certifier 1 Certifyin (Check only one) 2 Medical	g Physician: To the b Examiner: On the bas and manne	est of my kno is of examina or stated.	wledge, death	n occurred at the time vestigation, in my op	e, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and n date and place	anner as , and due	stated. to the cause(s)
	Within To the comp	A D 4								29d. Date sign	ed (Month	, Day, Year)
			30. Name and address of person	y Hell	of death (Ita-	0 23a) /Tuna		756		6/22	109	
			ISRAEL ALTER	9901 MED	ICAL G	ENTER !	DRIVE, ROC	ckville	MARYLAN	10 208	50	
State Registrar  31. Date filed (Month, Day, Year)  32. Registrar's Signature  33. Registrar's Signature  34. Aparlo												

DHMH 17 Rev 1/2001

			State Registrar			Cei	rtificate of l	Death	lental Hyg R	teg. No.2 0 0 9	22275
	Dhusisi		1. Decedent's Nam	ne (First, Middle, Last)					2. Date of Dear		3. Time of Death
	Physicia /Medic		Ebteha						06 <sup>Month</sup> / 2	24 / 2009	
	Examin	er		'If not institution, give s				Location of Death		4c. County of Dea	
<i>~</i>			Shady  5. Social Security N	Grove Ho		s. last birthday)	Rock If Under 1 Year	ville If Under 24 Hrs.	8. Date of Birth	Montgo 9. Bir	thplace (State or Foreign
	Funeral Director		219-06-	·8091 1 <sup>1</sup>	м 2√2 г 89	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day 2/28/	1920	Iran
/land	at at		Usual Residence of 10a. State	10b. County	10c. C	City, Town or Lo	cation				10d. Inside City Limits
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th the	or 28 e not	Director	10e. Street and Nu				10f. Zip Code		1	10g. Citizen of What Co	ountry?
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<b>-UU30</b> hours after death with the Maryland	ene. than "natural", or items 23a or 28a-f show w. Medical Evaminer must be notified at	by Funeral	<ol> <li>Marital Status</li> <li>Never Mar</li> <li>X Widowed</li> </ol>	ried 2 Married	12. Was Decedent Ever in the Armed Forces?  1 □ Yes 2 □ No If Yes, Give Year or Dates:		was Decedent of H If Yes, specify Cuba 1 □Yes	ispanic Origin? (Sp in, Mexican, Puerto Specify:	Rican, etc.)	Cnooify:	
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وَ	if Health and Menta Item 27 is marked other traumatic ev			Name/Relationship (Ty	pe. Print)	19b. Mailii	ng Address (Street	and Number or Rui	al Route Numbe	er, City or Town, State,	Zip Code)
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Derm Derm	Department of Important: If it any injury or o		21. Signature of F	uneral Service Nicens	" Matte					sai Morcus	-
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Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If Hem 27 is injury or other traumat		21. Signature of Fu	uneral Service	Livensee	06							n T. F h. D.(		es Funer	ral Home	
Physician	9	23a. Part I. Enter t				the death	. Do not								Approximate Interval	
/Medical Examiner	4	failure. List or Immediate Cause	•	Ct-	<sub>ine.</sub> ib Wounds (	of Back									Between Onset and Death	
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To the within To the comple	Med	29b. Signature and		er an	d manner stated	1				nse number				Date signed (M		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Dorothea Merle O'Brien 2009 01 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner itizens 115.N a If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 5. Social Security Number Country) Maryland **Funeral** Days 1 □ M 2 🛣 F 08/15/1919 89 213-16-6949 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h County "natural", or items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 X No Director Catonsville MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 912 Prestwood Road 21228 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: <u>^</u> White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Banking Operations Banking 12 other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any Injury or other traumatic event Be William J. O'Brien Dorothy Mae Merle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 615 Congress Avenue, Havre de Grace, Maryland 21078
20c. Location - City or Town, State William J. O'Brien (Nephew) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1) Burial 2 □ Cremation 3 □ Removal from State 07/06/2009 Baltimore, Maryland Parkwood Cemetery 4 Donation 5 Dother (Specify) ature of Funeral Service Licensee Zellman Funeral Home, P.A. 123 S. Washington St., Havre de Grace, MD 21078 Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) aiserse **Physician** /Medical Due to (or as a consequence of): Examiner 10 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to ( r as a consequence of) Examine death certificate be executed attending physician and for use as the burial-tran P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of deatb? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performed? Yes 2 No has 2 No certificate 1□ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Mann of Death Certification: Injury Hospital or Attending 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 **Physician** 30 a M June Ralph J. Parnell /Medical 4c. County of Death 4b. City, Town, or Location of Death a. Facility Name (If not institution, give street and number) Examiner Doctors Hospital Prince Georges

9. Birthplace (State or Foreign Country) Lanham If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Days Hours Min. Yrs 577-32-6462 Director 81 April 18,1928 North Carolina Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evant for item by notified an once. 10b. County 10a. State 1 Yes 2 □ No Director Maryland Prince Georges Lanham 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 9902 Lanham Severn Road 20706 S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1. 12 Ves 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ⊡Yes 2 🖺 No Maryland 21215-0036 Specify þ White 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Bus/Charter Operator Metro 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Claude Parnell Ethel Trebble ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Marlene Dottellis (daughter) 1117 North Blackmoor Dr. Murrells Inlet, S.C.29576 altimore, Date 20c. Location - City or Town, State 20a. Method of Disposition
1 Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Cheltenham Vet. Cem. July 1,2009 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature Funeral Service Licensee Rendon/Hale Funeral Home 23a. P. n.t. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Myo Candia mediate Cause (Final **Physician** HRS Acute disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 

Ectopic pregnancy Month Year Day in the past 12 months? 5 ☐ Other (specify) □Yes 2 No ed by the detached f 9 Unknown 9 Unknown signed by the detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 🗖 No 3 Probably 4 Unknown funeral director, page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 ☐ Pending investigation n 24 hours after death.

The Funeral Director: After the further of the further than the fu 1 ☐Yes 2 ☐No 2 Accident 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho

To the Fune

completely f (Check only one) the 29d. Date signed (Month, Day, Year) 29c. License number son who completed cause of death (Item 23a) (Type, Print) Jane Suite222, State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene

	1 - State of Maryland / Dep	artificate of Death	Reg. No.
Physician	1. Decedent's Name (First, Middle, Last)		2. Date of Death  Month 6/9/2009  3. Time of Death  Year 640am M
/Medical	Earle LeRoy Peddicord, Sr.  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	
Examiner	1421 Hunting Wood Rd.	Annapoli	Anno Arundol
Funeral Director	5. Social Security Number 215-22-6819	If Under 1 Year   If Under 24 Hrs.   Months Days Hours Min.	8. Date of Birth (Month, Day Year) 6/9/2009 9. Birthplace (State or Foreign MD Country)
Maryland Ind	Usual Residence of Decedent  10a. State	ocation polis	10d. Inside City Limits 1 ⊡Yes ※☆ No
fer death with the Mar fer death with the Mar ritems 23a or 28a-f st ritems 23a or 28a-f st ritems 23a or 28a-f st	10e. Street and Number 1421 Hunting Wood Rd.	10f. Zip Code 21403	10g. Citizen of What Country? USA
y, Maryland 21215-0036 and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f show her traumatic event, Itm Medcal Examination to the modified at To Be Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 X X es 2 No 44-46 Year or Dates:	Was Decedent of Hispanic Origin? (Spit Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 XXIo Specify:	necify Yes or No-Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White
21215-00 ed within 72 hou ygiene. ner than "natura ft, the Medical E	(Specify only highest grade completed) (Giv life.  Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mantal Hyglene. 77 is marked other than "natural", or traumatic event, the Modern Evan To Be Completed by F	12 B 17. Father's Name (First, Middle, Last) Harry Peddicord	anker  18. Mother's Nam  Mary Bet	Banking e (First, Middle, Maiden Surname) Z
re, Maryla s 1 and 2 should 1 f Health and Men item 27 is marke other traumatic. To	19a. Informant's Name/Relationship (Type. Print) 19b. Mai	ling Address (Street and Number or Run Hunting Wood Rd.	ral Route Number, City or Town, State, Zip Code) Annapolis, MD 21403
Baltimore, permit. Pages 1 an Department of Hea Important: If item; any injury or other once.	4 Donation 5 Other (Specify) Maryland	ematory or other place)  Veterans Cem 6/15	Date 20c. Location - City or Town, State  /2009 Crownsville, MD
Ban permii Impor any ir		22. Name and Address of Facility Har 2 Ridgely Ave. An	desty Funeral Home, P.A.
Physician /Medical	23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):		or respiratory arrest,  Approximate Interval Between Onset and Death
f8760, tificate be executed tificate be executed to gphysician and as the burial-transit tificate Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):		
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al Records, The law requires the cate has been signe, page 2 should be of			24a. Was an autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
Vital Risidian: The certificate herector, page	25. Was case referred to medical examiner?	Other:	th (Check only one)
on of ding Phys h. After this funeral dia	1 Yes 2 No Inspire 2 ER/Outpati 27. Mann of Death 1 Islatural 5 Pending (Month, Day, Year) 2 Accident investigation	of 28c. Injury at	ome 5 ☑ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred
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To the Hospital  Within 24 hours a  To the Funeral I  completely filled		ath occurred at the time, date and place investigation, in my opinion, death occu	a, and due to the cause(s) and manner as stated.  urred at the time, date and place, and due to the cause(s)
S C D withing to the company of the	29b. Signature and the of certifier	29c. Nicense number	29d. Date signed (Month, Day, Year)
12+1	30. Name and address of person who completed cause of death (Item 23a) (Typ	E FO 300 AM	10p15 am 22pm
State Registrar	31. Date filed (Month, Day, Year)  JUN 2 3 2009  32. Regetrar's Signature	parl	

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician June 26, Louise Friday Phillips 2009 7:00pm/Medical 4c. County of Deeth 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Glade Valley Nursing Home Walkersville Frederick If Under 1 Year If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Dey, Year) **Funeral** Days 1□ M 2ĬŽF Months Director 579-14-2322 88 Feb 12, 1921 Pennsylvania Usual Residence of Deceden 10d. Inside City Limits Peges 1 and 2 should be filed within 72 hours aftar death with the Maryland 10b. County 10c. City, Town or Location 10a. State 7 is marked other than "natural", or Nems 23a or 28a-f show traumatic event, the Mactical Examiner must be notified at 1 DXYes 2 □ No MD Frederick Frederick Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1919 Belford Drive 21702 USA by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2公 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamentary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) end Mental Oswald Friday Ruth McMunn 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) f Health Item 27 i 1919 Belford Drive Frederick, Alan D. Phillips/son MD 21702 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ŏ 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 06/27/09 Woodbine, MD 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Service License MO1251 Beverly L. Heckrotte, P.A. Clarksville, Ne MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examine inding physician and usa as the burial-transit Attending Physician: The law requires that the death certificete ba executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): signed by the at d be datached for 23b. Did tobacco use contributa to the cause of death? Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yea 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed cartificate has t lirector, pega 2 s 2 X No 1 ☐ Yes 2 ☐ No 1 Tes director 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this After this funerel 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 24 hours efter death. Funeral Director: A 2 Accident filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 5 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier completaly (Check only one) Nurse Preand manner stated To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 05060 5 EG 30. Name and address of perspn who completed cause of death (Item 23e) (Type, Print)

State Registra

31. Date filed (Month, Jan 2

1475 laney 1

werne trederick

CRUP

Begistrar's Signature

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32.

			State of Maryland / De	partment of Fertificate of	Health and Ment			22201	
			Registrar  1. Decedent's Name (First, Middle, Last)	erinicate or		Reg. N	lo.	3. Time of Death	
	Physicia	ın			N	Month D	2009 Year	1500 M	
	/Medic		Sarah L. Pleasanton  4a. Facility Name (If not institution, give street and number)	4h City Town o	or Location of Death	une 24,	c. County of Death	1300	
	Examin	er	8801 Archid Drive	Delmar	// LOGGIOTI OI BORRI		Wicomico		
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	ay) If Under 1 Year	If Under 24 Hrs. 8. D	ate of Birth Month, Day, Yea	9. Birtho	place (State or Foreign	
	Director		221-20-3616 1 M 2X F 75 Yrs	Months Days		t. 24, 19		iware	
	nd >		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location			1	0d. Inside City Limits	
	aryla shov	7					Ι'	1 ☐ Yes 2X No	
	the M	Director	MD Wicomico Delma	10f. Zip Code		10a. C	Citizen of What Cour	ntry?	
	hours after death with the Maryland tural", or items 23a or 28a-f show at Evarilint must be invitined at		8801 Archid Drive	21875			U.S.A.	,	
	ms 23	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 1	3. Was Decedent of h	Hispanic Origin? (Specify)	Yes or No-	14. Race - Americ		
٥	or iter		Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No	If Yes, specify Cub 1 ☐ Yes 2 ☑ No	ban, Mexican, Puerto Ricar Specify:	n, etc.)	Black, White,	etc.	
5	ral",	d b	3X Widowed 4 □ Divorced If Yes, Give Year or Dates:	TERS ZENO	эреспу.		Specify: W	hite	
215-0036	within 72 hours after death with the Marylan ene. than "natural", or items 23a or 28a-1 show the fractor Exaction in the templified at	Completed	(Specify only highest grade completed) (G	cedent's Usual Occu ive kind of work done	during most of working	16b.	Kind of Business/Inc	dustry	
2	vithin	du	Elementary/Secondary (0-12) College (1-4or 5+)	e. DO NOT use retire Sales Cle:			Retail		
20	filed within 72 Hygiene. other than "na ent, In Medic	ပို	12 17. Father's Name (First, Middle, Last)	Sales Cle	18. Mother's Name (Firs	st, Middle, Maide			
ă	d be ental ked o c eve	To Be	Archibald Lank		Priscil	.la Geor	ge		
Maryland 21	shoul nd M mar	F		ailing Address (Street	et and Number or Rural Ro			Code)	
Š	alth a 27 is 27 is sr train		Diane LeCompte (Daughter) 794	l Naas Ro	ad Salisb	ury, MD	21801		
altimore,	of He		20a. Method of Disposition 20b. Place of Discemetery, of	sposition (Name of crematory or other pla	ace) Date	20c.	Location - City or To	wn, State	
Ĕ	Page ment ant; if		I District 2 Micremation 3 Differentiation State 1		marva06-26-20	009   Del	lmar, Dela	ware	
Salt	permit. Pages 1 and 2 should be filed wir Department of Health and Mental Hygien Important; If item 27 Is marked other th any injury or other traumatic event, IIIs once.		21. Signature of Funeral Service Licensee	22. Name and Addre	neral Home				
n	70 E # 9		12 gwell	13 East	<u>Grove Street</u>		, DE 199		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or head failure. List only one cause on each line.	enter the mode of dy		spiratory arrest,		Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition resulting in death)	Lung S	ancer				
	/Medical Examiner		Due to (or as a consequence of):						
		er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):						
	uted	Examiner	Sequentially list conditions, if any, leading to immediate cauce. Enter U.c. High Cause (Disease or injury that initiated events						
a î	cate be executed oblysician and the burial-transit	Exa	resulting in death) Last Due to (or as a consequence of):						
8760	nte be nysicia ne bui	dical	d						
Ŏ	ng ph as th		IF FEMALE:						
ROX	death certific e attending p id for use as t	an/I	23b. Was decedent pregnant  1  Live birth 2  Fetal death	3 ☐ Ectopic pregnan	псу		23d. Date of deliv Month	rery Day Year	
o.	the a	Physician/Me	1   Yes 21   No 9   Unknown 9   Unknown	5 ☐ Other (specify)					
٦.	The law requires that the de ate has been signed by the angle 2 should be detached		Part ii. Other significant conditions contributing to death but not resulting in th	e underlying cause gi	iven in Part I.	23e. Did tobacc	o use contribute to t	he cause of death?	
gs,	sign d be	d by			,	1 ☐ Yes	2 No 3 Pro	bably 4 Unknown	
ecords,	w requires that s been signed t should be deta	Completed				24a. Was an	24b. Were auto	opsy findings available	
Re	The lay cate has page 2	dmo				autopsy performed	prior to co death?	ompletion of cause of	
Vital			25. Was case referred to medical		26. Place of Death (Ch	1 ☐ Yes 2 ☐	No 1 ☐ Yes	2 □ No	
	ysiclan: is certific director,	To Be	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	atient 3 DOA Ot	ther: 4 \( \sum \) Nursing Home		e 6 ☐ Other (Speci	ify)	
J Of	Attending Physiclan: Ir death. ector: After this certific by the funeral director,	n: T	27. Manner of Death  → Natural 5 □ Pending  28a. Date of Injury (Month, Day, Year)  Inju	ne of 28c. Injury	ury at 28d.	Describe how in	njury occurred		
IVISION	uttendir death. ctor: Al y the fu	atic	2 Accident investigation	M 1 [	□Yes 2□No				
Ž O	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	, street, factory, office	28f. I	Location (Street City or Town, St	tand Number or Rur tate)	al Route Number,	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one)  29a. Certifier (Check only and manner stated and manner stated)	leath occurred at the or investigation, in my	time, date and place, and popinion, death occurred a	due to the cause at the time, date	e(s) and manner as and place, and due t	stated. to the cause(s)	
	o the vithin of the omple	Mec	and manner stated.  29b/Signature and title of certifier	29c. Licen	nse number	29d.	Date signed (Month,	Day, Year)	
	A/3N		Matte X how Bonnoulla	00 06	4/04<		125/0		
	1119		39 Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print)	10.1-	16	100/-	1	
	9		Path SONDER Becamueller no (	castal H	topice Po [	30× 173	33 Salls	bury MD	
				11	1			1	

DHMH 17 Rev 1/2001

Registrar

JUN 29 2009 June 1.

Physician	
/Medical	
Examiner	

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ital Mudical Evaninar must be redifficed and any injury or other traumatic event, Ital Mudical Evaninar must be redifficed and any injury or other traumatic event, Italiand and once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, 10

	1 - State Registrar		Cer	rtificate of L	Death		R	eg. No.2	09	222	82
	1. Decedent's Name (First, Middle, Last)				2	. Date of Deal	th	Veer	3. Time of E	Death	
n	Jacqueline Susanne	Rocks			Jı	une 24	, 2009	Year	10:24	А м	
al	4a. Facility Name (If not institution, give stre	4b. City, Town, or			4c. County	of Death					
er	267 Tidewater Circl		Pres			Caro	line				
-	5. Social Security Number 6. Sex	7. Age (In yrs	last birthday)	If Under 1 Year	If Under 2	24 Hrs.   8	. Date of Birth		9. Birth	place (State or	Foreign
		2⊠F 80	Yrs.	Months Days	Hours	Min.	Date of Birth (Month, Day) Mar 21,	Year)	Cou	on, MA	
	Usual Residence of Decedent	00				P	lar ZI,	1929	DUST	.on, rin	
	10a. State 10b. County	10c. C	ity, Town or Lo	cation						10d. Inside City	Limits
ō	Maryland Caroline		1X Yes	2 □ No							
ect	10e. Street and Number		Preston	10f. Zip Code			1	0g. Citizen of	What Cou	ntry?	
ă				216	E E		'	USA	vviiat oou	110 y 1	
rai	267 Tidewater Circl									1 12	
mu	11. Marital Status	Was Decedent Ever in U Armed Forces?	J.S. 13. \	Was Decedent of H If Yes, specify Cuba	ispanic Orig in, Mexican,	gin? (Speci , Puerto Ri	ty Yes or No- can, etc.)		ce - Ameri ck, White,	can Indian, etc.	
Ϋ́		1 ∐Yes 2 🖾 No If Yes, Give	1	1 □Yes 2⊠No	Specify:			Specia	y: W	hite	
Be Completed by Funeral Director	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:						101 101 111		al. ale	
lete	15. Decedent's Educati (Specify only highest grade co	on ompleted)	I (Give	dent's Usual Occup kind of work done o	luring most	of working	- "	16b. Kind of B	iusiness/ir	austry	- 11
dm		College (1-4or 5+)	lite. L	DO NOT use retired Homemake				Our	1 Hom	P	
ပ္ပ	12	<del> </del>		пошешаке			Fi 141-2-11-				
Be	17. Father's Name (First, Middle, Last)					-		Maiden Surnai	ne)		
ပ္	Alix Mongeon				M	igonn	e Guil	bault			
	19a. Informant's Name/Relationship (Type.	,	1	ng Address (Street							
	Susanne Goodnight -	Daughter	267	Tidewate	r Cir	cie,	Presto	n, MD	2165	<u> </u>	
	20a. Method of Disposition	20b.	Place of Dispo-	sition (Name of natory or other plac	e)	Dat		20c. Location	- City or T	own, State	
	1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)		te of H			6/30/	2009	Silve	Spr	ing, MD	•
	21. Signature of Funeral Service Licensee	1	22	2. Name and Addres	ss of Facility	у		// 730 T	201+1	more Av	anua
Lewis Af Casch's Funeral Home, P.A. Hyattsvi											
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.										Approximate	
shock, or heart failure. List only one cause on each line.  Immediate Cause (Final										Interval Betw Onset and D	
disease or condition resulting in death)											
Due to (or as a consequence of):											
_	Sequentially list conditions, b.  Due to (or as a consequence of):										
ine	Cause (Disease or injury										
xan	that initiated events c resulting in death) Last	Due to (or as a conse	quence of):							<del></del>	
E E		200 10 (01 00 0 00130	quonoo on.								
Medical Examiner	d										
Me	IF FEMALE:	16							W-1-		
an/	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet	al death 3 🗆	☐ Ectopic pregnanc	y				ate of deli <sup>,</sup> Ionth		ear
sici	1 □Yes 2 ☑No	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5	Other (specify)	·					,	
۲h	9 Unknown						I D			4b 4 ala	41-0
Be Completed by Physician/	Part II. Other significant conditions contrib	outing to death but not re	sulting in the ur	nderlying cause give	en in Part I.		l .			the cause of de	
ed .							1 🕪	es 2 □ No	3 ☐ Pro	obably 4 □ U	nknown
Set							24a. Was a			opsy findings a	
E							autop: perfor	med? 2 ☑ No	death?	ompletion of ca 2 □ No	iuse oi
Ö	25. Was case referred to medical				26 Place	of Death /	1 □ Yes 'Check only or		1 🗆 Tes	2 🗀 140	
	examiner?  1 Yes 2 No Hos	pital: 1 ☐ Inpatient 2 [	ER/Outpatier	nt 3 🗆 DOA Oth	or:			ence 6 🗆 O	thor (Space	n/6.4)	
Ĕ		28a. Date of Injury	28b. Time of					ow injury occu		ary)	
tior	1 ✓ Natural 5 ☐ Pending investigation	(Month, Day, Year)	Injury	f 28c. Injur Worl M 1 □	ć? Yes 2.∐.ľ						
ica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At I	nome farm str			-	of Location /S	treet and Num	ber or Ru	ral Route Numb	ber.
iri	4 ☐ Homicide determined	building, etc. (Spec	ify)	,,,			City or Tow				
Medical Certification: To	29a. Certifier 1 Certifying Physic	ian: To the best of my kr	nowledge deat	h occurred at the ti	me date on	nd place o	nd due to the	cause(s) and r	manner as	stated	
lica	(Check only 2 Medical Examiner	: On the basis of examin	nation and/or in	vestigation, in my c	ppinion, dea	ith occurred	d at the time,	date and place	, and due	to the cause(s)	
Med	one)	and manner stated.		29c. Licens	a numbar			29d. Date sign	ed (Month	Day Year)	
	29b. Signature and title of certifier		am-				.   '	Jale sign	(WOIII	)	
				DOC	533	32 S		6/0	IT/C	4007	
	30. Name and address of person who comp				0	,				-	
	Melinda Buto			in Arv	e Y	rcs+	on n	i On	116	2 2	
te	31. Date filed (Month, Day, Year) JUN 2 9 2009	32. Registrar's Sign	nature								
ar	JUNE & COOR KENNE	m. 7									

Sta Registr

09-04849 Patricia Risk Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar				Certific	cate of	Deat	h				Reg. N	No.		
Physicia		Decedent's Name (First, Midd	le,Last)			-	_				- 12	2. Date of	Death			3. Time of Death
dical Exami	ner	Patricia Jean	Risk	isk							Month June 1	9, 200		1	0930 hrs	
*)		4a. Facility Name (if not institution	on, give s	, give street and number)  4b. City, Town, or Location of Death						Death			4c. County o	f Death		
/		727 Gleneagle Drive	727	GLene	agles	s Driv	7e	Fort \	Vashing	gton				Prince G	eorge'	s
Funeral		5. Social Security Number	6. Sex			n yrs. last b		If Und	er 1 Year	If Under	24Hrs.	8. Date o	f Birth (N	M/DD/YYYY		nplace (State or
Director		482-38-0263		4 2 XF	7	<b>7</b> 5	Yrs	Month	s Days	Hours	Min.	Dec.	6 1	1933	Foreigr Cou	ntry) Iowa
		Usual Residence of Decedent		-LB	<u> </u>			<u> </u>		<u> </u>		PCC.	0, .			
any		10a, State 10b. County			10	c. City, Tow	vn or Locat	ion							$\neg \neg$	10d. Inside City Limits
		Maryland Prin	ca G	annaa		Ft. W	lachir	ator								1 Yes 2 No
Maryland 28a-f show 1 at once,	횽	10e. Street and Number	. u	eorge.	3	1 C. N	1431111	10f. Zip					100.0	Citizen of Wh	at Coup	
or 28	ire							·					109. (		at Court	uyr
ith the Maryland 23a or 28a-f sho notified at once.	eral Director	727 Gleneagles							0744					USA		
th wi	Jer.	11. Marital Status  1 Never Married 2 X M		12. Was De Armed F		er in U.S.			ent of Hispa fy Cuban, I					14. Race White		an Indian, Black,
or dea	Fune			1 Yes	2 <b>X</b> _	No			ΧNο						VII- 2	4 -
s afte	Š		- 10	Yes, Give Year or Dates:		Tao.	-					J. J	Tac	Specify:	Whi	Property and the second
hours natur	fed	15. Decedent's Education (Spe Elementary/Secondary (0-12)			1-4 or 5+)		a. Deceden during m		king life. D				100	b. Kind of Bus	iness/in	idustry
24 [ -4]	Completed			•	1-4 01 5+)		D = = 4 =		.a. M					M - 12	1	
215-0036 be filed within 72 ntal Hygiene. rked other than '	티	12 17. Father's Name (First, Middle	l act\	3			Regis	tere			Namo /	Eiret Mide	lo Maid	Medio Jen Surname)		
filed of the filed of the filed		•	, Lasty						'					en Jumame)		
2121 wild be fi Mental I marked c event,	To Be	Roy B. Zoffka  19a. Informant's Name/Relations	ship (Typ	e Print )		I 1	19b Mailine	Address	(Street :			Walto		City or Town	o State	Zin Code)
MD 2 d 2 shou tth and 1 n 27 is r	-			,					,					•		
e, M l and 2 Health item 2	L V	Donald Risk/ H 20a. Method of Disposition	usba	nu			e of Dispos				Гし.	Date	1119	ton, MI	City or	O / 44 Town. State
- S		1 Burial 2 XX Cremation	n 3 🗌	Removal f	rom State		atory or oth								-	
ti Pay		4 Donation 5 Other S				Hunt	t Cre	ema to	ry		<u>June</u>	29,	2009	9 Walde	<u>orf,</u>	MD.
Baltimore, permit. Pages 1 a Department of He Important: If it injury or other t		21. Signature of Funeral Service	License		NIK	<b>→</b> i			Address o		Hun			al Home		
	-	23a. Part I. Enter the disease, or	complie		015		1303	35 01	d Was	shing	ton	Rd.	Wald	dorf.	4D.	20601 Approximate Interval
Physician /Medical		failure. List only one cause	on each	n line.							il diac or i	espiratory	arrest,	SHOCK, OF HEE	"1	Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	_	ypertensi			tic Cardi	iovascu	ılar Dise	ase						Death
A.P.			h-	ue to (or as a	a consequ	ierice or):										
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ed nsit	Examin	events resulting in death) Last	Di.	ue to (or as a	a consequ	ience of):										
ords, P.O. Box 68760, w requires that the death certificate be executed as been signed by the attending physician and ishould be detached for use as the burial - transit	_	LINDENDED		AMENDED	42 1	ner ME	2 089	3 772	21/09	TT						
O, be e	n/Medica	UNPENDED													-	<u> </u>
18760, rtificate build physic as the build purious the build as the build purious th	ξ	IF FEMALE: 23b. Was decedent pregnant in t	he	23c. If yes,					2	7c-t:-				23d. Date of		- Vene
leath certi e attending for use as	ä	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnan 4 Pregnant at time of death 5 Other (Specify)							pregnan	су	Į.	Month	Di	ay Year		
Box 68 e death certi the attendin ed for use a	Physicia	1 Yes 2 V No 9 Un	known	9 Unkn	own		3 Ot	ner (Spe	cny)							
D. B.	문	Part II. Other significant condi	tions c	ontributing t	o death bi	ut not result	ting in the u	underlying	cause giv	en in Par	t I.	23e. D	id tobac	co use contri	bute to t	he cause of death?
res that to signed by the detac	Completed by	metastatic carcinoma	а									1	Yes 2	No 3	Proba	ably 4 🗸 Unknown
ds,	ted					•						24a. V	/as an	1 24b. V	Vere aut	opsy findings available
OF law ra has by 2 sho	ğ												utopsy erformed	p		ompletion of cause of
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Division tal or Attendii rs after death. al Director:  ded in by the fu	읉		ding stigation						1 Ye	s 2	No					
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Divi Hospital or 24 hours after Funeral Dir	Certification:	4 Homicide	rmined	(Specify)	_							Of 10W	n, State	,		
Hos 24 h Fun etely														and manner		
To the Hospital within 24 hours To the Funeral completely fille	Medical	one) 2 Medical Exa	miner: C	On the basis and manner :	of examin stated.	ation and/o	r investigat	tion, in my	opinion, o	death occ	urred at	the time, o	late and	place, and d	ue to the	e cause(s)
	ž	29b. Signature and title of certification						290	c. License	number		ar 1000	29	d. Date signe	ed (Mon	th, Day, Year)
		The of	11	7	2/7	2	and T		O.C.M	I.E.	OCN	E	J	une 20, 20	)09	
		30. Name and address of person	n who co	mpleted cau	se deal	th (Item 23a	1)	/ • I								
BBID		Theodore M. King, Jr.	, MD.	Assist	ant Med	lical Exa	miner	111 Pe	enn Stre	et, Bal	timore,	MD 21	201			
	ate	31. Date filed (Month, Day, Year)			egistrar's	Signature	, ,		,				_			
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DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 0:45 PM M July 6, 2009 Betty Rebecca Ridgley /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 6602 Cherry Hill Drive Frederick Frederick 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/21/1944 **Funeral** Months Days Hours Min. 1 □ M 2 🛛 F 219-42-9955 64 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Marical Examiner mant be retained at anone. 10a. State 10h County 1 ☐ Yes 2 🔀 No Director Frederick Frederick MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21702 United States 6602 Cherry Hill Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes ②☐ No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 ☐ Never Married 2 ☐ Married 1 □Yes 2k□No Specify: Specify: white à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) health dept. nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lewis Wetzel Mary Smith ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6602 Cherry Hill Dr., Frederick, MD 21702 James Ridgley/ spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Olivet Cemetery | 7/10/2009 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Keeney and Basford PA Funeral Home Jacquelle Krok MO1222 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** HOCARDIAL disease or condition resulting in death) /Medical s a consequence of): Examiner tatu if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2☑No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, After this certificate has been signed by the funeral director, page 2 should be detached n 24 hours after death.

ne Funeral Director: Af
pletely filled in by the fur Medical within 24 ho

To the Fune

Baltimore, Maryland 21215-0036

6 ☐ Could not be 3 Suicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29b Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

rederes Drine

State Registrar 31. Date filed (Month, Day, Year)

4 - Homicide

33/ Registrar's Signature

BOLK

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar

29b. Signature and title of certif

31. Date filed (Month,

JUN 2 9 2

William Duboyce, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12158 Central AVe., Mitchellville, MD

29c. License number

D47603

29d. Date signed (Month, Day, Year)

6/26/09

20721

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** James William Spitznas June 27, 2009 04:00 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Allegany 200 Braddock Road Frostburg Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1**™** M 2□ F 80 September 25, 1928 Director 218-24-8379 Maryland Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10c. City, Town or Location 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medicel Examinar must be notified at 1XYes 2 No Director Maryland Frostburg Allegany 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 220 Braddock Road Pages 1 and 2 should be filed within 72 hours after death with U.S.A 21532-Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces'
Yes 2 
f Yes, Give 2□No Korean 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify. Specify: ð Year or Dates: Con Click 3 Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other thar Education Teacher 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) h and Mental H 7 is marked otl Be Pearl Tharp Earl Spitznas traumatic ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other tra once. 21532-Laura Spitznas Daughter Maryland 220 Braddock Road Frostburg 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Burial 2 Cremation 3 Removal from State July 01, 2009 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery Flintstone Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility oku Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final Kins **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? icate has been signed , page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an autopsy performe certificate 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Other: 4 \sum Nursing Home Hospital: 1 ☐ Yes 2 100 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) Certification: To this Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a Medical Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the

within 2 + nds

State Registrar 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State of Maryland State of Maryland	/ Depa <i>Cen</i>	rtment of H tificate of L	ealth and M Death		iene	09 22287		
Physicia		1. Decedent's Name (First, Middle, Last)  NOR BERT  SELIGS	SON			2. Date of Deat Month	th Day	Year 2200 M		
/Medic Examin		4a. Facility Name (If not institution, give street and number)  10 Silverwood Circle, #7		,.	Location of Death		of Death ne Arundel			
Funeral Director		5. Social Security Number 6. Sex 7. Age ( <i>In yrs. last</i> 561–40–1323 17 M 2 F 87	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 29,	Year)	Birthplace (State or Foreign Country)     Germany		
show	or	Usual Residence of Decedent  10a. State 10b. County 10c. City, T  Maryland Anne Arundel	Town or Loc		napolis			10d. Inside City Limits  1		
with the N ta or 28a-1 Lee notiff	Direct	10e. Street and Number 10 Silverwood Circle, #7		10f. Zip Code	21403	1	_	g. Citizen of What Country? U_S_A_		
ite, Intally lated ZIZIO-000 stand 2 should be filed within 72 hours after death with the Maryland the haith and Mental Hygiene. It has and Mental Hygiene. It marked other than "natural", or items 23e or 28e-f show other traumatic avant, the Maxical Exercities in as be inclifted at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	111	/as Decedent of Hi Yes, specify Cuba □ Yes 2XX\o	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ee - American Indian, ck, White, etc. v: White		
within 72 hou iene. Than "nature than "nature the maile.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	ation during most of work od Supply			usiness/Industry				
yidilid Zila buld be filed with Mental Hygiene arked other tha atic avant, Ingli	To Be Co	17. Father's Name (First, Middle, Last)  Max Seligsohn			18. Mother's Name	e (First, Middle, 1 Belitzer		10)		
B 0, 5 2 3					and Number or Rura Circle,		-			
Page Tent o		I Burial 2 M Cremation 3 L Removal from State   _		sition (Name of latory or other place Crematory				City or Town, State		
permit. Departm Importa any inju		21. Signatur Prieral Service Licenses						uneral Home olis, MD 21401		
Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Inmediate Cause (Final disease or condition resulting in death)  Due to (or as a consequer	CRE		g, such as cardiac	or respiratory arr	est,	Approximate Interval Between Opey and Death		
cate be executed by sician and the buriat-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of the consequen								
The Colids, F.C. BOX 80100.  The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	hysiclan/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnance 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat 9 □ Unknown		ate of delivery onth Day Year						
w requires that been signed be should be detailed	by P	Part II. Dther significant conditions contributing to death but not resulting	ng in the un	derlying cause gre	en in Part I.	23e. Did to		tribute to the cause of death?  3 Probably 4 Unknown		
	Completed					24a. Was a autops perfore 1 \( \text{ Yes} \)	sy med?	Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No		
Or VICAL Physician: this certifica ral director, p	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 EF	₹/Outpatien	t 3□ DOA Oth	er: 4 ☐ Nursing Ho	1	ne) ence 6 🗆 Oth	ner (Specify)		
nding ath. r: After e fune	ertification;	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation	8b. Time of Injury		y at k? Yes 2 □ No	28d. Describe h		tred ber or Rural Route Number,		
pital or Atte urs after de: aral Directo	O	4 Homicide determined 288. Place of Injury - At homi- building, etc. (Specify)				City or Tow	n, State)			
the Hosp thin 24 ho the Funt mpletely fi	Medical	29a. Certifier  (Check only one)  2 Medicel Examiner: On the basis of examination and may ner stated.  29b. Signature and title of certifier	n and/or inv	restigation, in my o	pinion, death occur	red at the time, d	date and place,	and due to the cause(s)		
51 D		parcel of Frentan	1	D	21438		Jun	MAZIO 2009		
15		30. Name and address of person who don pleted cause of death (Item 2	3a) (Typ)	EFENSE	HIGHW.	Ay Ann	VAPOLI	M N 21401		
Sta Registr		31. Date filed (Month, Day, Year) 2009 32. Begistrar's Signatur	9. A	all						

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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 Month June **Physician** James Howard See 30, 8:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany 37 Furnace Street Lonaconing 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday) **Funeral** Year Months Days Hours Min. 1 X M 2 □ F 68 214-36-6630 Maryland Director 07/22/1940 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Exemity in ust be modified at Director MD Corriganville 1 ☐ Yes 2 X No Allegany the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21524 21206 Proenty Road, P.O. Box 38 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No 1960 -I Yes, Give Year or Dates: 1964 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☑ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 📆 No Specify <u>م</u> Specify. 3 Widowed 4 Divorced 1964 White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Concrete Finisher Construction 12 should be filed with and Mental Hygier 7 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ellen Howard Loring See Virginia Oglesbee ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any Injury or other traun Emma E. See / Wife P.O. Box 38, Corriganville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD Vet Cem @ Rocky Gap 07/02/2009 Flintstone, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Rome, P.A. Signature of Funeral Service Lice 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COLORECTAL CARCINDMA **Physician** 18 A/ disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physiclan: The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician a for use as the burial-P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 5 ☐ Other (specify) the 9 Unknown à signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform page death? 1 ☐ Yes 2 ☐ No certificate 2 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Residence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Hospital or Attending 1 Natural 5 Pending Injury death. 1 □Yes 2 □ No 24 hours after death.
te Funeral Director: A
bletely filled in by the function investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 ី Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical npletely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the the To the within 7 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0023371 July 1, 2009 3+ or person who completed cause of death (Item 23a) (Type, Print)
Qamar Zaman, M.D., 904 Seton Drive, Cumberland, MD 30. Name and add 21502 nds 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JUL 0 1 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 Month 13:53 PM Tune Raymond reter **Physician** 25 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore City The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year)
APRIL 28, 1928 Birthplace (State or Foreign
Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number . Age (In vrs. last birthday) **Funeral** Months Days Hours 1 **X** M 2 □ F PENNSYLVANIA 81 Director 313-30-1580 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show notified at 1 Yes 2 No Director QUEENSTOWN MARYLAND **OUEEN ANNE'S** 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Numbe ō ms 23a or UNITED STATES 21658 117 GOVERNORS WAY SOUTH r death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Was Deceuen Armed Forces? 1 ♥ Yes 2 □ No Black, White, etc. ntal Hygiene. ed other than "natural", or itel event, the Medical Examiner Pages 1 and 2 should be filed within 72 hours after Yes Tes, Give 1 Never Married 2 X Married 21215-0036 1 ☐ Yes 2 X No Specify: WHITE þ 3 Widowed 4 Divorced Year or Dates: 1951-1953 Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done do life. DO NOT use retired) during most of working (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) **PHYSICIAN** PEDIATRICS 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event once. Be MARTHA AGNES MAY PETER ALBERT SRSIC မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 117 GOVERNORS WAY SOUTH, QUEENSTOWN, MARYLAND 21658 MARY E. SRSIC/WIFE Baltimore. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) JUNE 30 ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation ST PETERS CEMETERY 2009 QUEENSTOWN, MARYLAND 5 Other (Specify) 21. Signature of Ju FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 23a. Part 1. Enter the disease, or complications that seused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Sclerosis atera Immediate Cause (Final 0 00 **Physician** disease or condition resulting in death) /Medical as a conseq Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of, or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician an as the burial-t Division of Vital Records, P.O. Box 68760 Physician/Medical attending IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23h. Was decedent pregnant Live birth 2 - Fetal death 3 Ectopic pregnancy Month Day in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 9 Unknown the 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 🗌 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Inpatient Other: 4  $\square$  Nursing Home 5  $\square$  Residence 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 6 Other (Specify) မ this 27. Manner of Death

1 Natural

2 Accident 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day 5 Pending investigation Injury 1 🗌 Yes 2 🗌 No death. I Director: A 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 3 Suicide determined completely filled in by 4 ☐ Homicide within 24 hours a the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical ledical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

2

Registrar DHMH 17 Rev 1/2001

State

Robert

31. Date filed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

LD

mD Phi)

32. Registrar's Signature

mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Physician /Medical Examiner  Funeral Director	4a. Facility Name (If not institution, give street and number) 3210 North Leisure World B	anck 4b. Cit		2. Date of Death Month	Day Year	3. Time of Death
Examiner  Funeral  Director	3210 North Leisure World B	4b. Cit		June 23		1:45 p M
Director	5. Social Security Number 6. Sex 7. Age		y, Town, or Location of Deat		4c. County of Death Montgoi	
yland	135-28-8748 1□M 2□F 7	Months	er 1 Year   If Under 24 Hrs s Days Hours Min.		9. Birth Cou 1933 New	place (State or Foreign ntry) Jersey
a-f s	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgomery	10c. City, Town or Location Silver Spi	ring			10d. Inside City Limits 1 ∐Yes 2 🛣No
sa or 28 the not	10e. Street and Number 3210 N. Leisure World Blvd		Zip Code 20906	109	g. Citizen of What Cou USA	ntry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, 1 in 1 Medical Event near the notified at once.  To Be Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Evarmed Forces?  1 □ Yes 2 ☑ No. If Yes, Give		eedent of Hispanic Origin? (Specify Cuban, Mexican, Puer 2 No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White, Specify:	
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nd 2 sho alth and 27 is m ir traum	19a. Informant's Name/Relationship (Type. Print)  James H. Schanck/Son		ess (Street and Number or F Coton Farm C			
Pages 1 arment of Hee ant: If item ury or othe	20a. Method of Disposition  1 ☐ Burial 2 St Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disposition (N cemetery, crematory of Metropolitan	r other place) Ju	ne 24	Oc.Location - City or T lexandria,	
permit. Departi Importi any inj	21. Signature of Funeral Service Licensee	22 Name Franc 500 T	and Address of Facility Cis J. Collin University Bl	s Funeral vd. W., S	Home Inc. ilver Spri	ng,MD 2090
tificate be executed  ug physician and as the burial-transit ledical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	f the Liver  consequence of):  consequence of):	ode of dying, such as cardia	c or respiratory arres	st,	Approximate Interval Between Onset and Death 6 months
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	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injurbuilding, etc.	ry - At home, farm, street, fact (Specify)	ory, office	28f. Location (Str City or Town,	reet and Number or Ru , State)	ral Route Number,
Hospi 4 hou Funer ely fill	29a. Certifier (Check only one)  Certifying Physician: To the best of Medical Examiner: On the basis of and manner states.	examination and/or investigat	red at the time, date and pla tion, in my opinion, death oc	ce, and due to the ca curred at the time, da	ause(s) and manner as ate and place, and due	s stated. to the cause(s)
To the I within 2 To the I complet	29b. Signature and title of pertifier	1	29c. License number		9d. Date signed (Monti	n, Day, Year) -4, 2009
15	30. Name and agrees of person who completed cause of de		D39190			1,2001
State	Joseph Garrett Reilly, MD  31. Date filed (Month, Day, Year)  32. Registra	3418 Oland	wood Court, C	lney, MD	20832	

			1 - For State Registrar	State of Maryla	•		lealth and	Mental Hyg	iene g. No.	9	222	291
			1. Decedent's Name (First, Middle, La	st)				2. Date of Deat Month	h Day	Year	3. Time of	Death
	Physici /Medic		Micollus Noel St	OW				June 27			2:48	A M
	Examin		4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	r Location of Dea	ıth	4c. County			
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pre	A I		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or L	ocation					10d. Inside Ci	ity Limits
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the c	1.28a	irec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	/hat Cou	ntry?	
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de s	eme	Funerai Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of I	lispanic Origin? ( an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		e - Ameri k, White,	can Indian, etc.	
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						DS	2323	>	06-2	-9-	200	9
			30. Name and address of person who	complete cause of death	(Item 23a) (Type							*
5f	1-3		Khalid Waseem M.I			Hagerstow	n,MD 217	740				
	Sta Registi		31. Date filed (Month, Day, Year) JUN 3 0	32. Redistrar's S								

# Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		State     Registrar  1. Decedent's Name	ne (First Middle	Last)		Ce	rtificate c	of Death	2.	Date of Dea	Reg. No.	UUJ	3. Time of Death
Physicia /Medic		Suzanne		Sibert						June 2	Day	)9 Year	5:45 P M
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Funeral Director		5. Social Security N  216-60-4  Usual Residence of	809	6. Sex 1 ☐ M 2 【X F	7. Age ( <i>In yr</i> s. 57		Months Da		Min.	(Month, Day	y, Year)	Cou	nington, D.C.
ryland	_	10a. State	10b. County		10c. Cit	ty, Town or Lo	ocation						10d. Inside City Limits
he Ma 28a-f s	ecto	MD	Montgor	mery	Dama	scus	10f, Zip Coo	40			10g. Citizen o	of Mihat Cou	1 □Yes 2MNo
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death	ner	11. Marital Status		12. Was Dece	edent Ever in U.	.S. 13.	Was Decedent	of Hispanic Origin Cuban, Mexican, F	? (Specif	fy Yes or No-	14. F	Race - Ameri	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Evariment in the molified anone.	P P	1 ☐ Never Marr 3 ☐ Widowed	ried 2 Marrie 4 Divorced	Armed Fo 1 ☐ Yes If Yes, Giv Year or D	<sup>2</sup> ₩ <sup>No</sup>		1 ☐ Yes 21 🔀		ruerto nic	san, etc.)		<sup>Black,</sup> White, <sup>c<i>ify:</i> Whi</sup>	
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	23b. Was deceder in the past 12 1 Yes 2 9 Unknown	2 months? █No	1 Live	tcome of pregnibirth 2 Teta nant at time of a nown	al déath 3	☐ Ectopic pregr ☐ Other (specif					Date of delive Month	very Day Year
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altimore, Maryland 21215-0036 mit. Pages 1 and 2 should be filed within 72 hours aft partment of Health and Mental Hygiene. portant: If item 27 is marked other than "natural", or portant: or other traumatic event, the Medical Event Re.	Completed by	15. Decedent's E (Specify only highest g Elementary/Secondary (0-12)	Education rade completed) College (1-4or 5	5+)	Decedent's (Give kind life. DO N		ation during most of work 1)	king	16b. Kind of I	Business/Indu	stry
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/lan uld be Venta irked itic ev	P B	Clarence Sweitzer	r				Daisy B	rowning			
Tary 2 sho and l	ľ	19a. Informant's Name/Relationship		195	. Mailing Ad	dress (Street	and Number or Ru	ral Route Numb	er, City or Tow	n, State, Zip C	Code)
e, N l and lealth			Daughter			ol Ridg	<u> </u>	illersv Date		ID 2110 - City or Tow	
MOFO		20a. Method of Disposition 1 ☐ Burial 2 ★ remation 3				(Name of y or other plac	i				
Baltimor permit. Pages Department of Important: If it any Injury or o		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		Atlant			y ↓6/29 <sup>ss of Facility</sup> Har	/2009	Glen Bu	rnie,	MD D A
Balti permit. Departr Importa any Inji		13- 2. Ch-					Ly Ave. A				P.A.
Physician /Medical		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	y one cause on each lir a. <b>PoSSIB</b> C	ne.	CARDIA		ng, such as cardiac		rrest,	0	Approximate Interval Between Inset and Death IN UTES
Box 68760, eath certificate be executed attending physician and infor use as the burial-transit	edical Examiner	Sequentially list conditions, it may be a first conditions of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence							=
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ds, P.O. I	Ď	Part II. Other significant conditions	contributing to death be	ut not resulting i	n the underly	ring cause giv	en in Part I.		obacco use co res 2 □ No		cause of death?
Division of Vital Records, To the Hospital or Attending Physician: The law requires the within 24 hours after death. To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be despited.	Completed							24a. Was autor perfo 1 □Yes		. Were autops prior to comp death? 1 □ Yes 2	sy findings available pletion of cause of □No
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on of iding Phy th.  After this funeral di	tion: To	27. Manner of Death  12 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ent 2 ER/Ou lry 28b.	Time of Injury	28c. Injur Worl	4 LJ Nursing H	ome 5 Residence			
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	Me	29b. Signature and title of certifie	4			29c. Licens			29d. Date sign		
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12+1		30. Name and address of person who			(Type, Print)	14044	066753 1 Parkwa	A	. 15-	110	21/01
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Registi		JUN 23	2009 Dene	ar's Signature	pa	Les.					

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Examin				give street and numbe				r Location of Death			County of Death	man la
Funeral		5. Social Security N	ongate I		Age (In yrs. i	ast birthda	Bowie y) If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	rth	9. Birthu	place (State or Foreign
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ryland	_	10a. State	10b. County			y, Town or I	Location				1	0d. Inside City Limits
he Ma 28a-f s	Director	MD		George's	Bo	wie						1 Ž¥Yes 2 □ No
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death	Funeral	11. Marital Status	119000 100	12. Was Deceder	nt Ever in U.	S. 13	B. Was Decedent of H	Hispanic Origin? (Sp	ecify Yes or No		4. Race - Americ	
filed within 72 hours after death with the Maryland Hygiene. Hygiene. Then "natural", or Items 23a or 28a-f show ent, the then "natural" or Items 21a or 28a-f show ent, the the natified.	þ	1 ☐ Never Mari 3 ☐ Widowed	ried 2 Married	Armed Forces d 1X1Yes 2[ If Yes, Give Year or Dates	□No		1 Tes, specify Cub	an, Mexican, Puerto	Hican, etc.)		Black, White,  Specify: Whi	
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within ene. <b>than</b>	Completed	Elementary/Seco		College (1-4o	r 5+)		. DO NOT use retire Cutter	d)		Giar	nt Foods	
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uld be Venta Irked tic ev	To B	Carl P.	Snyder					Katie 1	Mosland	ler		
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s 1 ar of Hea item	i	20a. Method of Dis	sposition		20b. P		position (Name of ematory or other pla		Date		cation - City or To	own, State
Page ment c ant: If ury or			☐ Cremation 3 5 ☐ Other (Spe	□ Removal from Statecify)	e I		an's Cem.	i	/2009	Che]	Ltenham,	MD
permit. Depart Import any Inj once.		21. Signature of F	uneral Service Lic	censee	•	i i	22. Name and Addre		eall Fu	neral e, M		
		23a. P . Enter	the case, or co	omp in ions that caus	ed the death					_	20713	Approximate Interval Between
Physician /Medical		Immediate Cause disease or condition resulting in death)	(Final on	_a. Mula		u 5	quomou	sell Ca	ung	wwy	princy	Onset and Death
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ed sit	iner	Sequentially list con it any, reading to in cause. Enter Unde Cause (Disease or	onditions, infrediate erlying	b. Due to (or a	is à consequ	ience of).						
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require een sig nould b						<del></del>			10	Yes 2	No 3 Prol	oably 4 🗆 Unknown
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fan;   rtifica stor, p	Be C	25. Was case refer	rred to medical					26. Place of Deat	1 ☐ Yes h (Check only		1 □ Yes	2 No
hysic this ce	2	examiner? 1 ☐ Yes 2 ☐	No	Hospital: 1 ☐ Inpa	itient 2	ER/Outpati	ent 3 ☐ DOA Oth			/	☐Other (Special	fy)
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Attenc death ctor: by the	ficat	2 ☐ Accident 3 ☐ Suicide	investigat 6 ☐ Could not determine	t be 28e. Place of I	njury - At ho	me, farm, s	M 1 C	lYes 2 □No	28f. Location	(Street and	d Number or Rum	al Route Number,
ital or after all Directions all Direction to the contraction of the c	Certification:	4 Homicide	determine	building,	etc.*(Specify	()	•		City or To	wn, State)		,
To the <b>Hospital or Attending Physician</b> : The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier (Check only one)	Certifying  2 Medical Ex	Physician: To the best caminer: On the basis and pranner	of examina	wledge, de tion and/or	ath occurred at the ti investigation, in my	me, date and place, opinion, death occur	and due to the	e cause(s) , date and	and manner as a place, and due to	stated. o the cause(s)
To t Vithi Com	Ž	29b. Signature and	d title of certifier	Hei	Anu	N	29c. Licens	21438	>	29d. Date	e signed (Month,	Day, Year)
4+1		30. Name and add	ress of person w	no ampleted cause of	f death (Item	23a) (Type	Priot) EYEN!	21438 SE HIGH	WAY /	TNNA	Pous M	121401
Star Registra		31. Date filed (Mor	JUN 22	2009 32. Regis	strar's Signat				*			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2009 **Physician** Month Year 18, а м June 7:25 Swaback /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Heritage Harbour Health and Rehab. Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M **XX**F Months Davs Hours Min. 109-10-5104 91 Director June 7, 1918 New York Usual Residence of Decedent 1∩a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Item 27 Is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Modical Examinar in ust be notified at Nassau New York Roslyn Heights Director 1 ☐ Yes 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? s 1 and 2 should be filed within 72 hours after death with 1 of Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or " 123 Parkway Drive 11577 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2XXXNo þ Yes. Give Specify. Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Levy Josephine Kohn ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Swaback/son 930 Astern Way, #404 Annapolis, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 permit. Pages Department of Important; If It any Injury or o ŏ 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) #altimore Crematory 6/20/2009 Baltimore, Maryland 21. Signaturu — uneral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of and burial-trar exect Due to (or as a consequence of) Box 68760. attending physician requires that the death certificate be Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy ξ in the past 12 Month Year 5 Other (specify) P.0. the Yes ģ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? Jas page 2 autopsy certificate perform 1 ∐Yes 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No After this of funeral dire 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital or Within 24 hour Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier

Registrar

State

31. Date filed (Mont

of person who completed cause of death (Item 23a) (Type

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Items 24a and 25 per phys. G893 7/13/09 dk

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** May 22, 10:45 PM Kathleen E. Scheve 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 715 Maiden Choice Lane #206 Catonsville Baltimore 8. Date of Birth (Month, Day, Year)
July 31, 1 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 □ M 2 √ F Yrs. Maryland 88 1920 Director 214-16-6433 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marken Evanther must be notified at once. 28a-f show 1 ☐ Yes 2 ☐ No Director Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 715 Miaden Choice Lane #206 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 21 No Specify Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) dept of educaton vocational rehab counselor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Drushler Charles A. Scheve 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sister Charlotte Sobler/cousin 715 Maiden Choice Lane #206 Catonville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signatu a of Funeral Service Liounsee

Wade Director 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ago ombocytopen) de to (or as a consequence f): **Physician** 3 months disease or condition resulting in death) /Medical Examiner 4/0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine 9/0 Due to (p as a consequence of) attending physician a for use as the burial-P.O. Box 68760 Physician/Medical law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day 5 ☐ Other (specify) signed by the a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy perform page certificate I 1 □ Yes 2 1 No 1 ☐Yes 2 ☐ No Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 DResidence 6 Other (Specify) 1 Yes 2 No this Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After the 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation hours after death.
uneral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after

To the Funeral Dire

completely filled in b 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D38762 09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5411 Ba/x 21229 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

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Registrar

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		For	State of Ma	aryland / Dep			iemai my	giene	
		State Registrar		Ce	rtificate of	Death		Reg. No.	3 Time of Deat
Physici	ian	Decedent's Name (First, Middle, L.		<b>01</b>			2. Date of Dea	Day Ye	ear
/Medic			Nellie A.	Shonert	4h City Tourn o	Location of Death	July	4 200 4c. County of	
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Funeral Director		216-16-2108	1□M 2\\ F 8	Ven	Months Days	Hours Min.	June 2	1924	Country) Maryland
		Usual Residence of Decedent							
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e Ma	Director	Maryland Cecil	L	E1kton					
章 g 章	Dire	10e. Street and Number	_		10f. Zip Code			10g. Citizen of Wha	
ath w	ral	250 Spears Hill			2192		:6. V N		States American Indian,
er de itemi	Funeral	11. Marital Status	12. Was Decedent Armed Forces? 1 XYes 2 ☐ I	World 13.	Was Decedent of H If Yes, specify Cubi	an, Mexican, Puerto	Rican, etc.)	Black,	White, etc.
s aff	by	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	if Yes, Give Year or Dates:	War II	1 ☐ Yes 2 📉 No	Specify:		Specify:	White
hou		15. Decedent's		16a. Dec	edent's Usual Occup	pation		16b. Kind of Busin	
Deficiency in the standard of the control of the control of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or any highly or other traumatic event, it is more any other traumatic event, it is more and the control of the control	Completed	(Specify only highest of Elementary/Secondary (0-12)	grade completed) College (1-4or 5	life	e kind of work done DO NOT use retire	during most of work d)	ing		
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othe vent,	Be	17. Father's Name (First, Middle, La	ist)			18. Mother's Nam	e (First, Middle	, Maiden Surname)	
uid b Ment irked atic e	2	Robert Remmel				Frances			
sho and is me		19a. Informant's Name/Relationship	(Type. Print)		ling Address (Street				tate, Zip Code)
and and in 27		Bonnie L. Racin	e/Daughter		3 01d E1k				1921
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinational Be rotified at once.		20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3	☐ Removal from State	20b. Place of Disp cemetery, cre	osition (Name of ematory or other pla	ce) Jul	Date y 6,	20c. Location - Ci	ity or Town, State
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		resulting in death)	Due to (or as	a consequence of):	0				
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ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that is its lead exerts.	Due to (or as	a consequence or,					
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eath cert attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		П =			23d. Date	of delivery
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		For State	State o	f Marylan		ertificate of		nd Me	_	_	911110	2220
	_	Registrar  1. Decedent's Name (First, Middle.)	l a a th		CE	erunicate of	Deam		Date of De	Reg. No.	. 400.	3. Time of Death
Physicia	an	i. Decedent's Name (First, Middle,		п 1 0	,				Month	Day		
/Medic		4a. Facility Name (If not institution,		Earl Sny	yder	4b. City, Town, o	r Location of		July_	3	2009 County of Death	1
Examin	er	Union Hospital	give street and nai	ilber)		Elktor		Dodin		10.	Cecil	•
Funeral			. Sex	7. Age (In yrs. I	last birthday	) If Under 1 Year	If Under 24		Date of Bir	th	9. Birth	place (State or Foreig
Director		293-12-1044	1∭ M 2□ F	85	Yrs.	Months Days	Hours	Min. F	EB 5,	192	4 Öĥ	nio
p ,		Usual Residence of Decedent		140. 00								10d. Inside City Limits
anyla shov	5	10a. State 10b. County			y, Town or L							1 X Yes 2 □ No
he M	Director	Maryland Ceci	1		Elktor	10f. Zip Code				10a Cit	izen of What Cou	
a or			0			·	ı		}			•
eath	Funeral	2 Colonial Mano		edent Ever in U.	S. 13	21921 Was Decedent of H		in? (Specif	v Yes or No		nited St	
r Iter	Ē	1 ☐ Never Married 2 ☐ Marrie	Armed Fo d 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	rces? 2 □ No 194	2-	. Was Decedent of H If Yes, specify Cubi		Puerto Rio	án, etc.)		Black, White	
urs a	β	3 Nidowed 4 Divorced	If <b>₹e</b> s, Gi Year or D	ve rates: 197	1	1 □Yes 2 🛣 No	Specify:				Specify: W	hite
72 ho natur	Completed	15. Decedent's (Specify only highest	Education		16a. Dec	edent's Usual Occup	oation during most o	of working		16b. K	ind of Business/I	ndustry
ithin ne.	ם	Elementary/Secondary (0-12)	College (1	I-4or 5+)	`life.	DO NOT use retire	d)			Ι.	m	
led w lygien her ti		12	4)		Pro	fessional			er First, Middle		Transpor	rtation
be find Hed of the find hed of	Be	17. Father's Name (First, Middle, La						_		, maiden	Samame)	
hould d Me mark matic	은	Vinton Rudolph  19a. Informant's Name/Relationship			10h Mai	ling Address (Street		ie Si		ner City o	or Town State 7	in Code)
d 2 s Ith an 27 Is trau		Lynn M. Rea/Dau				Beachview						
Hea Hea tem		20a. Method of Disposition	gircei	20b. P		position (Name of ematory or other plan		Date	9		ocation - City or T	
Pages ent o ht; If I		1 ☐ Burial 2 X Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State		ris & Co., I	, ,	July 4 2009	4,	,	Wast Cha	ster, PA
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Madical Examinar must be notified at ance.		21. Signature of Funeral Service Li		K. /		22 Name and Addre	es of Facility				west_one	Ster, IA
Depar Depar Impor any Ir once.		Daniel	e . H.	0.0	-   I	licks Home	e for b	Stre	als, l et. El	P.A. Iktor	n. MT) 2	1921
		23a. Part1. Enter the disease, or conshock, or heart failure. List or	omplications that only one cause on e	caused the death								Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	ily one cause on c	c ho	Va	scular	Ac	cid	out			Onset and Death
/Medical		resulting in death)	Due to	(or as a consequ	uence of):	0)0 1		010.				
Examiner		Sequentially list conditions	b									
ed sit	Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consequ	uance off:							
xecut and J-tran	хап	that initiated events resulting in death) Last	c	(or as a consequ	uence of):					-		
be e sician buria	dical E			(0. 00 0 00.0004								
ficate p phys s the	adic		d									
n certi inding use a	Ž	IF FEMALE: NA A- 23b. Was decedent pregnant		tcome of pregna							23d. Date of del	ivery
death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Preg	birth 2 ☐ Feta nant at time of c		B□ Ectopic pregnand □ Other <i>(specify)</i> _	cy 				Month	Day Year
tt the by th tache	Physician/Med	9 Unknown	9 ☐ Unkr	nown								
es tha	by	Part II. Other significant condition	s contributing to d	eath but not resi	ulting in the	underlying cause give	ven in Part I.		23e. Did	tobacco		the cause of death?
equir een s ould	ted	Caracternic	Opark	<del>1</del>				_	1 🗆	Yes 2	□ No 3□ Pr	obably 4 DUnknow
law las b	윤	Atnal 1	Sprilar	ion.					24a. Was	psy	24b. Were au	topsy findings available completion of cause of
cate h	Completed		)						perfo 1 □ Yes	ormed? 2 ⊠No	death? 1 □ Yes	2   No
ding Physician: The In. After this certificate he funeral director, page	Be	25. Was case referred to medical examiner?	Hospital:			To#	26. Place oner:	of Death (	Check only	one)		
Phys this ral dir	₽	1 Yes 2 No 27. Manner of Death	28a. Date	Inpatient 2  of Injury	ER/Outpati 28b. Time	ent 3 DOA	4 ⊔ Nur		5 Res		6 ☐ Other (Spe	cify)
d <b>lng</b> h. After funer	ion	1 Natural 5 Pending 2 Accident investiga	(Mor	nth, Day, Year)	Injury	Wor	rk? ]Yes 2∐N	ĺ	u. Describe	now siju	ny occurred	
Atten deat octor: by the	fica	3 ☐ Suicide 6 ☐ Could no	ot be 28e. Place	of Injury - At he	l ome, farm, s	street, factory, office						ural Route Number,
al or s after of in t	Certification: To	4 ☐ Homicide determin	build	ing, etc. (Specii	ry)				City or To	wn, Stati	e)	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical (		xaminer: On the !			ath occurred at the t investigation, in my						
To th Withir To th comp	Me	29b. Signature and title of certifier	2.			29c. Licen				29d. Da	ate signed (Monta	h, Day, Year)
		9 mon				D 6	9181			7	3/200	9
		30. Name and address of person w	^								-100	1
		Dr-TANMAY	SAMANT	, 106	130W	STREET	, EL	KTC	M,	MI	) 2192	

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

State Hegistrar

OHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

23a or 28a-f show

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

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Completed

Certification: To Be

Medical

IF FEMALE

1 Natural

3 Suicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29a. Certifie

**Physician** 

/Medical

Examiner

10a. State

Pages 1 and 2 s ment of Health ar

cate has been signed page 2 should be det

certificate has

this

thours after death.

funeral

filled in by the

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 9:05 AM 24 2009 MARY ELMYRA TAYLOR JUNE 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death QUEEN ANNE'S HEARTLAND HOUSE GRASONVILLE 8. Date of Birth (Month, Day, Y If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Year) **1922** Months Days Min. 1 □ M 2 X F Hours 87 Yrs MARYLAND 212-16-1759 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐Yes 2X No MARYLAND QUEEN ANNE'S CHESTER 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 118 DUNDEE AVENUE 21619 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. ☐Yes 2 Yes, Give 1 Never Married 2 Married 2 X No 1 □Yes 2 No Specify WHITE Specify: 3 XWidowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CLERK STATE GOVERNMENT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) RUTH KELLY W.A. SPARKS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 CHESLOU ROAD, CHESTER, MD 21619 SYLVIA TAYLOR/DAUGHTER-IN-LAW 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) STEVENSVILLE CEMETERY STEVENSVILLE, MD 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final YEARS CORONARY ARTERY DISEASE disease or condition resulting in death) Due to (or as a consequence of): CHRONIC ATRIAL FIBRILLATION **YEARS** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) CONGESTIVE HEART FAILURE YEARS resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ▼No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ¥ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 🗆 No 1 ☐Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

State Registrar

DHMH 17 Rev 1/2001

JOEL H. WILKERSON,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D0027055

29d. Date signed (Month, Day, Year)

JUNE 25, 2009

## Baltimore. Maryland 21215-0036

-	Exa	min
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

		State of Maryland / Depa			
		_ FOr	tificate of Death	Re	g. No. 2009 22300
Physician	,	1. Decedent's Name (First, Middle, Last)  Raymond Mason Tinker		2. Date of Death Month	Day Year
/Medica Examine		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	June 2	27, 2009   12:30 P™ 4c. County of Death
Zammei	-	Montgomery General Hospital	Olney		Montgomery
Funeral	- }	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day,	
Director		177-03-7221 95 Yrs.  Usual Residence of Decedent		Sept 11,	
arylan show	5	10a. State 10b. County 10c. City, Town or Loc			10d. Inside City Limits 1 ☐ Yes 🏖 No
ith the Mary		MD Montgomery Silver Spi	10f. Zip Code	10	Dg. Citizen of What Country?
72 hours after death with the Maryland ratural", or items 23a or 28a-f show dical Exprained rates by notified at		3681 S. Leisure World Blvd.	20906	J	JSA
r dea:	runeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
al", or	2	1 □ Never Married	I∐Yes 2∭XNo <i>Specify</i> :		Specify: White
within 72 hours after death with the Marylan giene. I than "natural", or items 23a or 28a-f show the Medical Expringer mast be notified at	Completed	15. Decedent's Education 16a. Deced	dent's Usual Occupation kind of work done during most of work		16b. Kind of Business/Industry
	E L	Elementary/Secondary (0-12) College (1-4or 5+)	NOT use retired)  Metal Worker		Construction
il Hygi other ent,	oe De	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, N	
Menta Anked arked atic ev	0	Harrison Tinker	Sarah Mas		
d 2 shoth the and the and traum			ng Address <i>(Street and Number or Rur</i> S. Leisure World E		City or Town, State, Zip Code)  Lver Spring, MD 20906
is 1 an of Heal item 2		20a. Method of Disposition 20b. Place of Dispo			20c. Location - City or Town, State
Page ment c tant: If lury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Jou	rney Crematory 06/	′29/09 T	Woodbine, MD
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, he was once.			bing niches Crematic		ce P.O. Box 784 Clarksville, MD 21029
	$\dashv$	23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.			
Physician			resated.		Onset and Death
/Medical Examiner		resulting in death)  Due to (or as a consequence of):	spensated. Heart due	nia	
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	HEALF Wife		
s be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events c			
bur jei	, o	d d			
leath certificate attending physi	Medic	IF FEMALE:			
attendi	lan/l	23b. Was decedent pregnant in the past 12 months?	Ectopic pregnancy		23d. Date of delivery  Month Day Year
the de	Pnysician/Medic	1   Yes 2   No 9   Unknown   4   Pregnant at time of death 5   9   Unknown	Other (specify)		
	D Y	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.		pacco use contribute to the cause of death?
requir seen s hould					es 2 No 3 Probably 4 Unknown
The faw cate has b	Completed			24a. Was a autops perforr	prior to completion of cause of death?
ician: Th	De Co	25. Was case referred to medical	26. Place of Deat		2) 1 Yes 2 No
ding Physician:  After this certific funeral director,	9	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien			ence 6 Other (Specify)
Attending Physician: r death. ector: After this certifics by the funeral director, f.	10n:	27. Manner of Death  1 Natural 5 Pending (Month, Day, Year)  2 \( \text{\text{\text{\text{Pending}}}} \) investigation	f 28c. Injury at Work?  M 1 □ Yes 2 □ No	28d. Describe ho	ow injury occurred
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rital or ral Dir after in Med in					
To the Hospital or Attending within 24 hours after death.  To the Funeral Director: Aft completely filled in by the fun	Medical	29a. Certifier (Check only one) 1 Gertifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or ir and manner stated.	h occurred at the time, date and place evestigation, in my opinion, death occur	, and due to the d red at the time, d	ause(s) and manner as stated.  late and place, and due to the cause(s)
To the within To the complete	Me	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Month, Day, Year)
66		Yar MD	0006803	-6	June 27, 2009
12+1		30. Name and address of person who completed cause of death (Item 23a) (Type,	Prince Philip	Dr 01	101 MD 20832
State	9	31. Date filed (Month, Day, Year) 32. Rigistrar's Signature		<u> </u>	
Registra	r	JUN2 9 2009 Server S.	acked		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3: Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1012 M 12510 /Medical 4a. Facility Name (If not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** of Man Medical Center ginmore and 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number Sex 7. Age (In yrs. last birthday) **Funeral** Days Min. Months Hours 1 □ M 2 🔀 F 82 125-46-7724 Director Italy Nov. 11,1926 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f shov permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Marical Examination rather traumatic and Injury or other traumatic event, If a Marical Examination and Injury or other traumatic event, If a Marical Examination and Injury or other traumatic event, If a Marical Examination and Injury or other traumatic event, If a Marical Examination and Injury or other traumatic event, If a Marical Examination and Injury or other traumatic event, If a Marical Examination and Injury or other traumatic event, If a Marical Examination and Injury or other traumatic event, If a Marical Examination and Injury or other traumatic event, If a Marical Examination and Injury or other traumatic event, If a Marical Examination and Injury or other traumatic event, If a Marical Examination and Injury or other traumatic event, If a Marical Examination and Injury or other traumatic event, If a Marical Examination and Injury or other traumatic event, If a Marical Examination and Injury or other traumatic event, If a Marical Examination and Injury or other traumatic event, If a Marical Examination and Injury or other traumatic events. Md Anne Arundel Arnold 1 ☐ Yes 2 XNo Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 250 Pendleton Court 21012 Italy Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Lebow Brothers Elementary/Secondary (0-12) College (1-4or 5+) Joseph A. Banks Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Antonino Galati Maria Antonietta Cicero 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pina Kobin / Daughter 250 Pendleton Court Arnold, MD 21012 Method of Disposition

1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Nother (Specify) Entorphement 20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Memorial Gardens Date 20c. Location - City or Town, State 20a. Method of Disposition June 22, Timonium, MD 2009 par ranco & Sons, P.A. Severna Park Funeral Home 195 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signature of Funeral Service Licensee 23a Part 1. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, o heart failure. List only one cause on each line Immediate ause (Final disease condition resulting in death) **Physician** hernianion meal /Medical Due to (or as a consequence of): **Examiner** middle Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division (or as a consequence of): Examine that the death certificate be executed and Due to (or as a consequence of): burial-Box 68760 physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Day in the past 12 months?
1 Yes 2 No Month Year Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 XNo 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician; 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pendina thin 24 hours arren co. the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🔏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated edical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature, and title of certifier 29c. License numbe

00gh

State Registrar Name and address of person who

31. Date filed (Month, Day, Year) JUN 23

DHMH 17 Rev 1/2001

mpleted cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

MD; 22

S. Greene St

Balhmore

### 1200C.M Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 4 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** O'OZ AM JUNE 2000 Elsie Belle Tavlor /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5. Social Security Number MEDICAL 6. Sex PLATA Year If Unit CHARL Birthplace (State or Foreign Country) (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🕇 F Hours Months Days Director 579-10-1442 100 July 22, 1908 South Dakota Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f shov event, its medical Eraculton country 1 Yes 2 No Director Maryland Charles Waldorf 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2600 Mill Hill Road 20603 by Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∏Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2 No Specify: Specify: White 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12th. Own Home Home Maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be be la Faye Loupe Georgia Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 l Kenneth Taylor/ Son 2600 Mill Hill Road, Waldorf, MD. 20603 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of F
Important: If ite
any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Huntt Crematory 4 ☐ Donation 5 ☐ Other (Specify) June 24, 2009 Waldorf, MD. 21. Signature of Funeral Service Licer 22. Name and Address of Facility Huntt Funeral Home 3035 Old Washington Rd. Waldorf, MD. 20601 MOI Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a con equence of) the death certificate be executed burial-tran and Due to (or as a consequence of) P.O. Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy rmed? 2 No 2 No 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 funeral 27. Manner of Death 1 Natural 2 ☐ Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fur death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title D0061652 cause of death (Item 23a) (Type, Print POST office Rd, healdon UITE-101 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

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		State Registrar				Ce	rtificate of	Death		eg. No. 🤰 (	0.9	22303
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Examin	er	4a. Facility Name (/. CHESTER		give street and nu HOSPITAL	,	R		r Location of Death ERTOWN		4c. Count KENT	y of Death	
Funeral Director		5. Social Security N 183-16-8	lumber	6. Sex 1 M 2 □ F		yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 2/23/19	Year)	9. Birth Cou	place (State or Foreign intry) PA
and w		Usual Residence of 10a. State	Decedent 10b. County		10c	. City, Town or Lo	ocation					10d. Inside City Limits
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Event and to nutified at once.	þ	1 ☐ Never Marri		Armed F	orces? 2	1	If Yes, specify Cuba 1 □Yes 2 No	an, Mexican, Puerto Specify:	Rican, etc.)		ick, White,	etc.
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Sta Registr		31. Date filed (Mon		- 32	Regist ar's S	ignature	And S	) JT.	Cles-	H/TOU	W /Y	() 7(1970)

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Funeral		Peninsula 5. Social Security Number		7. Ag		enler ast birthday)	Salis If Under 1 Year	Muni If Under 24 Hr		rth	Wi Com	place (State or Foreign
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arylan show	_		. County			, Town or Lo						10d. Inside City Limits 1 XYes 2 □ No
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filed within 72 hours after death with the Maryland Hygiene. ther than "natural" or items 23a or 28a-f show ont, the Medical Evanfrar must be notified at	Funeral Director	10e. Street and Number 529 Esquir	re Drit	7 <b>0</b>			10f. Zip Code 21801			U.S.	izen of What Cou	nury?
Jeath Jeath Jeanna	Jera	11. Marital Status		12. Was Decedent	Ever in U.S	3. 13. V	Vas Decedent of H	ispanic Origin?	Specify Yes or N		14. Race - Ameri	
after o		1 Never Married 2	2 X Married	Armed Forces? 1♥ Yes 2 ☐ I If Yes, Give	No		fYes, specify Cuba ☐Yes 2 XNo	an, Mexican, Pue Specify:	erto Rican, etc.)		Black, White,	etc.
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Physician /Medical Examiner	niner	shock, or heart failt Immediate Cause (Final disease or condition resulting in death)  Sequentially list condition if any, leading to immediate Cause, Envary Underlying Cause, Obsease or Injury	ſ	Due to (or as	d is me a consequ		hq					Interval Between Onset and Death
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hysio this o	2	1 Yes 2 No		lospital: 1   Inpatie		ER/Outpatien		4 🗀 Nursing	Home 5 ☐ Res	sidence	6 ☐ Other (Spec	ify)
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To the Hospital or Attending Physiclan: within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director, p.	Certifi	4 Homicide	determined	28e. Place of Injubul building, etc	c. (Specify	")			City or To	òwn, State	9)	ral Route Number,
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		1 _ State	Indelible Ink. Ensure All epartment of Health and M Certificate of Death	•	•
Physic		1. Decedent's Name (First, Middle, Last)  Barbara Rieger Hodsdon Ullyot		Date of Death     Month	Day Year 17 2009 1:10 PM
/Med Exam		4a. Facility Name (If not institution, give street and number) Ginger Cove Health Center	4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birth 1 ☐ M 2 ☑ F 83 Y		8. Date of Birth (Month, Day, )	
f show	or	Usual Residence of Decedent  10a. State  10b. County  Maryland  Anne Arundel  10c. City, Town			10d. Inside City Limits 1
with the Manual Nation 18 with the Manual 18 with 18 w	I Direct	10e. Street and Number  3311 River Crescent Drive	10f. Zip Code 21401	10g	g. Citizen of What Country? U.S.A.
partilling is, Ivial yially 212.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, In Medical Evant in another traumatic at any income.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 □ Yes 2 ☑ No  If Yes, Give  Year or Dates:	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto F 1 □ Yes ♣☐No Specify:	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
ithin 72 hound.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired)	ng	sb. Kind of Business/Industry  Merican Chemical Soc.
Idito Library	To Be Co	12 17. Father's Name (First, Middle, Last) Maurice George Rieger	Meeting Planner  18. Mother's Name Hele		
and 2 shou ealth and M n 27 is mar her traumat			Mailing Address (Street and Number or Rura. 33 Baker Avenue NW, S		
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permit. Departr Imports any Inji		21. Signature of Funeral Service Licenses	22. Name and Address of Facility Joh 147 Duke of Gloucest	_	
Physiciar /Medica Examine		23a. Part 1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.  Due to (or as a consequence of the condition of the co	cell ling Cauce		t, Approximate Interval Between Onset and Death
Physician: The law requires that the death certificate be executed rithis certificate has been signed by the attending physician and rall director, page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b.  Due to (or as a consequence of the conseque			
at the death certification of the attending stacked for use as	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Unknown   Unknown   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   4   Pregnant at time of death   9   Unknown   U	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
w requires that been signed b should be deta	ē.	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.		cco use contribute to the cause of death?
iclan: The law re certificate has be ector, page 2 sho	Completed			1 V	24b. Were autopsy findings available prior to completion of cause of death?  No 1 □ Yes 2 ▼No
<b>– D</b> • • •	ion: To Be	Tatalala o la citaling	me of 28c. Injury at 2 Work?	(Check only one) ne 5 Resident 8d. Describe how	
To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	M 1 □Yes 2 □No  n, street, factory, office 2	8f. Location (Stree City or Town,	et and Number or Rural Route Number, State)
ne Hospita n 24 hours ne Funera pletely fille	Medical C	29a. Certifier (Check only one) (Certifying Physician: To the best of my knowledge, one) (Check only one) (Certifying Physician: To the best of my knowledge, one) (C	death occurred at the time, date and place, a //or investigation, in my opinion, death occurre	and due to the cau	ise(s) and manner as stated. e and place, and due to the cause(s)
てて <u>り</u>	M	29b. Signature and little of certifier	29c. License number $0.06364$	29d	L. Date signed (Month, Day, Year)
12	5	30. Name and address of person who completes cause on eath (liem 283) (1	5767AG RD 300 AW	RUCKAN	mu 51401
Regis		31. Date filed (Month, Day, Year) 2009 32. Figistrar's Signature 4.	parl		

## ■ Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			it in black indelible ink. Ensur		
		For State Of Ma	aryland / Department of Health a	nd Mental Hygiene	
		Registrar	Certificate of Death	Reg. No. 2 () ()	22305
Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, Last)  Robert Mitchel  4a. Facility Name (If not institution, give street and number)	ell USilton  4b. City, Town, or Location of		J. 30 A
Funeral Director		5. Social Security Number 6. Sex 17. Age 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	e (In yrs. last birthday)  Type (In yrs. last birthday)  Type (In yrs. last birthday)  Type (In yrs. last birthday)  Type (In yrs. last birthday)  Type (In yrs. last birthday)  Type (In yrs. last birthday)  Type (In yrs. last birthday)  Type (In yrs. last birthday)  Type (In yrs. last birthday)  Type (In yrs. last birthday)		irthplace (State or Foreign Country) DE
with the Maryland a or 28a-f show	tor	10a. State 10b. County MD KENT	10c. City, Town or Location  ROCK HALL		10d. Inside City Limits 1 ☐ Yes 2 ☒ No
the 1	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What 0	Country?
th with 23a or		7055 ROCK HALL RD.	21661	USA	
after dea	by Funeral	11. Marital Status  1 □ Never Married 2 □ X Married  1 □ Never Married 2 □ X Married  1 □ Yes 2 □ X Married	Ever in U.S. 13. Was Decedent of Hispanic Origi		
72 hours "natural"		3 ☐ Widowed 4 ☐ Divorced Year or Dates:	100 December Heisel Convention		
be filed within 72 ntal Hygiene. of other than "nal event, In Modic	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5-	16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)  REFINISHER	of working 16b. Kind of Busines CONTRUCT	
filed I Hyg other ent, I	BeC	17. Father's Name (First, Middle, Last)		s Name (First, Middle, Maiden Surname)	1011
ald be Aenta rked tic ev	To B	ROBERT BRUCE USILTON	MARY	VIRGINIA REED	
s ma		19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and Number	or Rural Route Number, City or Town, State	, Zip Code)
and and and and and and and and and and		PENNY USILTON		, ROCK HALL, MD 2166	
permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other any injury or other traumatic event, once.		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place)  CHESAPEAKE CREMATION	Date 20c. Location - City of 5/25/09 STEVENSVII	
permit. Departm Importa any inju		21. Signature of Euneral Service Licenses	22. Name and Address of Facility FELLOWS, HELFEN	BEIN & NEWNAM FUNERA	
		23a. Part1. Enter the disease, or complications that caused	the death. Do not enter the mode of dving, such as co	HESTERTOWN, MD 21620 ardiac or respiratory arrest,	Approximate
Physician /Medical		shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition resulting in death)	ne. At traumm with Accordance of:	tic Injury	Interval Between Onset and Death
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be executed iician and burial-transit	Examiner	that initiated events c	a consequence of):	LO LA PROPERTO NA MENORAL	
e S e	cal	d	a consequence on).	CITIFICATION .	
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e law requires that the di has been signed by the e 2 should be detached	þ	Part II. Other significant conditions contributing to death bu	, , ,	23e. Did tobacco use contribute 1 ☐ Yes 2 ☐ No 3 ☐	to the cause of death?  Probably 4  Unknown
	Completed			autopsy prior t	autopsy findings available o completion of cause of ? es 2 \( \) No
iclan: The certificate ector, pag	Be	25. Was case referred to medical examiner?		f Death (Check only one)	
Phys this	2	1 Yes 2 No Hospital: Inpatie 27. Manner of Death 28a. Date of Injur		ing Home 5 Residence 6 Other (S	pecify)
Attending Physician: r death. ector: After this certific by the funeral director, I	Certification:	1 Natural 5 Pending 2 Accident investigation	y, Year) 8: 10 PM 1 □Yes 2 □No	11100	
tal or At rs after d al Direct led in by	Certifi	4 Homicide determined 28e. Place of Inju	ary - At home, farm, street, factory, office c. (Specify)	28f. Location (Street and Number or City or Town, State)	Rural Route Number,
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier  (Check only one)  1 CertifyIng Physician: To the best of 2 Medical Examiner: On the basis of and manner sta	of my knowledge, death occurred at the time, date and f examination and/or investigation, in my opinion, death	place, and due to the cause(s) and manner occurred at the time, date and place, and c	as stated. lue to the cause(s)
To th To th	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mc	nth, Day, Year)
10		30. Name and address of person who completed cause of de	eath (Item 23a) (Type, Print)  22 S. Gwalm St.	Beltimore MD	21701
Sta Registra		31. Date filed (Month, Day, Year) 32. Registra  JUN 2 5 2009	ar's Signature	MILLIME V	-100
		2011 20 2000	- P. II.		

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		For State Of Marylar  State Registrar		rtificate of			, No. 2 A A C	22307
		Decedent's Name (First, Middle, Last)				Date of Death	Day Year	3. Time of Death
Physicia /Medic		ERNEST LEE WHITE	HEAD	TR		UNE 25	2009	1039 AM
Examin		4a. Facility Name (If not institution, give street and number)		2.	r Location of Death		4c. County of Deat	
F		5. Social Security Number 6. Sex. 7. Age (In yrs	. last birthday)	GIRDLE?		Date of Birth	WORCES?	hplace (State or Foreign
Funeral Director		21290 3852 1XM 20F 31	Yrs.	Months Days	Hours Min.	(Month, Day, Y		untry) PRYLAND
PL .		Usual Residence of Decedent	ity, Town or Lo	ontion				10d. Inside City Limits
laryla shov	ō	29	RDLETA					1 ☐ Yes 2 ♠No
the N 28a-1	Director	MARYLAND WCRCGSTER 6-1, 10e. Street and Number	()) - ( //	10f. Zip Code		100	g. Citizen of What Co	untry?
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ems 2	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?	J.S. 13.		- Hispanic Origin? (Specit an, Mexican, Puerto Ric	fy Yes or No- can, etc.)	14. Race - Ame Black, White	
s after	by Fu	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No ☐ If Yes, Give		1 ∐Yes 2 <b>X</b> No	Specify:		Specify:	
id ( 1 1 1 1 2 1 2 1 2 2 2 2 2 2 2 2 2 2 2	ed b	3 ☐ Wildowed 4 ☐ Divorced Year or Dates:  15. Decedent's Education	16a. Dece	dent's Usual Occup	pation		Bb. Kind of Business	// <i>TE</i> Industry
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y lo	မ	19a. Informant's Name/Relationship (Type. Print)	SR 10h Maili	na Address (Ctreet	SHARO) and Number or Rural F		City or Town State	Zin Code)
perinificate, find I yialiu ZIZIS-0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and the reconflict of an once.		RHONDA WHITCHEAD	77 J		) HILL ROA			MD 21829
s 1 an if Hea item 2			Place of Dispo	osition (Name of matory or other place		e 20	oc. Location - City or	Town, State
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Dalti permit. Departr Importa any inju		21. Signature of Funeral Service Licensee	2:	2. Name and Addre	RY ZOC ess of Facility FOX	FUNERA	OL HOME	,
D SOFE9		M. Dale Hos	P	0 BOX 27	8 TEMPERI	ANCEVIL	LE, VIRGIN	NA 23442
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The lar te has age 2	dmo					autopsy performe	ed? prior to death?	completion of cause of
Italian:   Ian:   Italian:   Italian:	Be C	25. Was case referred to medical			26. Place of Death (		`	2 🗆 140
OI V Physic r this ce rral direc	일	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2	-	nt 3 🗆 DOA	her: 4 Nursing Home	e 5 esiden	nce 6 ☐ Other (Spe	ecify)
Ing P	ion:	27. Manner of Death  28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Wor	ry at rk? ]Yes 2 □No	d. Describe how	v injury occurred	
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier (Check only    Certifying Physician: To the best of my k						
thin 24	Medical	29b. Stanature and title once of the control of the	0	29c. Licen			d. Date signed (Mon	
F ≥ F 8		Matte & hour Browns	M	10 DGG	4645		6/25/69	}
		By Name and address of person who completed cause of death (It	em 23a) (Type,	Print)	100-1-			1
8A2		Pathy SOhrum Bergmueller	mo (c	xistal t	ospice Pc	Box	1733 S	alisbury MC
Sta		31. Date filed (Month, Day, Year) 32. Registrar's Sig	nature	2.1.1				/
Registi	ar	JUN & 0 2003 (Brews	p. 14	www				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Day Month **Physician** SHIRLEY G. 06 29 09. 2050 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner WMHS Braddock Campus Cumberland 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Months 1 □ M 2 👿 F OCT. 17,1929 MARYLAND Director 215-26-9691 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f shortraumatic event, the Medical Engineer must be realised at 1**Y**Yes 2 □ No CUMBERLAND Director MD ALLEGANY 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21502 U.S.A. 507 ROSE HILL AVENUE 2 should be filed within 72 hours after death in and Mental Hygiene.
Is marked other than "natural", or items 23 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: ş WHITE 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) RETAIL STORE SALES CLERK 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CLARA MAY GREEN ROBERT A. RITTER Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. 926 ARCTIC AVENUE, LaVALE, MD GARY L. WHITE / SON Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 07/06/2009 FLINTSTONE, MD 4 ☐ Donation 5 ☐ Other (Specify) M.S.V.C.-ROCKY GAP 21. Signature of Funeral Service Licenside 22. Name and Address of Facility
UPCHURCH FUNERAL HOME, P.A.
202 GREENE STREET, CUMBERLAND, MD 21502 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Dulmone Immediate Cause (Final Chamic Obstanctive lage nds Physician disease or condition resulting in death) /Medical Due to (or as a conseru-nce of): Examiner ere Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner Hyp-orthy roldism Hospital or Attending Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Iting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 100 24 hours after death.

Funeral Director: After this certific letely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) completely and manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified D0066070 00 30 8 person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of Igrigopula 900 Seton DRIVE Comber Land, MD 21502 x, Madhusudhar nes 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUN 30 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Weimer Warren Brian 6:50 A 2009 26, <u>June</u> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Allegany Moran Manor Westernport Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/20/1966 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 M 2 □ F 43 214-98-4443 Pennsylvania Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, I'm Medical Examinar must be notified at 1 ☐ Yes 2 No Director MD Garrett Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2948 Lower New Germany Road 21532 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Youth Supervisor 12 State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve once. Thomas Francis Weimer Rose Marie Robertson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon L. Weimer / Wife 2948 Lower New Germany Rd, Frostburg, MD 21532 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cumberland Crematory | 06/27/2009 Cumberland, MD 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signatur, of Funeral Service Libensee 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Neurological Deficit /Medical Due to (or as a consequence of): Examiner Post Transplant - Liver and Kidneys Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examine or Attending Physician: The law requires that the death certificate be executed Past History of Alcoholism attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) been signed by the should be detached 1 □Yes 2 □No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has a his certificate h I director, page performed' 1 □Yes 2 No 1 ☐ Yes 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 X Nursing Home 5 Residence 6 Other (Specify) this 1⊠(Yes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural ours after death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D09157 June 26, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Snow, M.D., 124 West Third Street, Cumberland, Maryland 32. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Mont

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav 10:42 A M JUNE 22, 2009 JOHN C. WALLER 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number Days Hours 1**X** M 2□ F Yrs 11/10/1947 Washington, D.C. 578-58-4446 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County 1XYes 2 □ No Maryland Prince George's Oxon Hill 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20745 1606 Jarvis Ave. 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) D.C. Government Forensic Tech 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John William Waller Louise Dixon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1606 Jarvis Ave. Oxon Hill, Maryland 20745 Edna Wal<u>ler / Wife</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 7/2/2009 4 Donation 5 Dother (Specify) Maryland Veterans Cheltenham, Maryland 22. Name and Address of FacilityPope Funeral Homes, P.A. 21. Signature of Funeral Service Lice 5538 Marlboro Pike Forestville, Maryland 20747 08 23a. Part1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardia Acute disease or condition resulting in death) Due to (or as a consequence of): Sep SIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dist for as a consequence of) Due to (or as a consequence of): Year death? Unknown available

**Physician** /Medical Examiner

Examiner

Physician/Medical

Completed by

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Certification: To

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**Physician** 

/Medical

Examiner

**Funeral** 

Director

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If item 27 is marked oth
y or other traumatic even

Department of Important: If it any injury or

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

other traumatic event, the Medical Examiner must be notified at

Funeral Director

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the Hospital or Attending Physlcian; The law requires that the death certificate be executed burial-trai attending physician for use as the burial detached signed to page

this n 24 hours after death.

ne Funeral Director; A
pletely filled in by the fi

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23	ic. If yes, outcome of pregna 1  Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	death 3 □ E		c pregnancy (specify)			23d. Date o Month		Year
Part II. Other significant conditions		, 7	ulting in the unde	erlying	g cause given in Part I.		23e. Did tobacco 1 ☐ Yes 2		ite to the cau	
Brain Tun Diabetes	w						24a. Was an autopsy performed? 1 □Yes 2 🖾 No	prio dea	re autopsy fi or to complet tth? ]Yes 2 []	ion of caus
25. Was case referred to medical		****			26. Place of De	ath (Ch	eck only one)			
examiner? 1 ☑ Yes 2 ☐ No	Ho	ospital: 1 ☐ Inpatient 2 🗹	ER/Outpatient	3□	DOA Other: 4 Nursing I	lome	5 Residence	6 □Other	(Specify)	
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigat	ion	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c. Injury at Work? 1 □Yes 2 □ No	28d.	Describe how inju	ry occurred		
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		28e. Place of Injury - At ho building, etc. (Specification)	ome, farm, street y)	t, fact	ory, office	28f. I	Location (Street a City or Town, Stat	nd Number ( e)	or Rural Rou	ite Number
29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physi	ician: To the best of my kno er: On the basis of examina	wledge, death o	ccurr	ed at the time, date and plaction, in my opinion, death occ	e, and urred a	due to the cause( t the time, date ar	s) and manr id place, and	ner as stated d due to the	cause(s)

29b. Signature, and title of certifier

29c. License number D40324 29d. Date signed (Month, Day, Year) JUNE 22, 2009

30. Name and a ress of person who completed cause of death (Item 23a) (Type, Print)

TERRY JODRIE, MD

and manner stated

TAKOMA PARK, MARYLAND 20912 7600 CARROLL AVENUE,

State Registrar

completely

the

32. Registrar's Signature 31. Date filed (Month, Day, Year) JUN 3 0 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month 2142 PM 2009 26 06 ar 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore of Maryland Medical Conter If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, -ebruary 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, Country) Maryland <sup>Year)</sup> 17,1945 Hours Days 1 **X** M 2 □ F Months 64 217-42-9053 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 XYes 2 No Washington Hagerstown Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21740 U.S.A. 829 West Washington Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dunkin Donuts 12 Baker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Shelden William Williams Arlene Nellie Baker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 829 West Washington Street, Hagerstown, Md. 21740 Anita G. Williams Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition ₩ Burial 2 Cremation 3 Removal from State Rose Hill Cemetery 07-01-09 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Andrew K. Coffman Funeral Home. Inc. R. hoel 40 East Antietam Street, Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BINA Due to (or s a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (cras a sonsequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? inditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 □ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No 2 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence

**Physician** /Medical Examiner executed burial-transi and Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be

**Physician** 

/Medical

Examiner

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28a-f show

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Funeral

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?7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Eromine must be neithed at

Department of Health a Important: If item 27 is any injury or other trau once.

Pages 1 8

and 2 should be filed within 72 hours after death with t leath and Mental Hyglene. m 27 is marked other than "matural", or items 23a or 2

Baltimore, Maryland 21215-0036

the Maryland

Examiner attending physician for use as the burial Physician/Medical as been signed by the should be detached þ Be Completed page 2 certificate Certification: To this After after death, I Director: Aff d in by the fur completely filled in by

	1 ∐ Yes 9 ☐ Unkr		No			
Par	Part II. Other significant co					
25	Was case	referre	d to mi			
٤٥.	examiner?					
27.	Manner of 1 Natura		5 □ P			

29a, Certifier

(Check only one)

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29b. Signature and title of certifier

30. Name and address of person who completed

	25. Was case referre examiner?	/
1	27. Manger of Death	
	1 Natural	5 Pending
	2 ☐ Accident	investigation
	3 ☐ Suicide	6 ☐ Could not b
	4 ☐ Homicide	determined

Nas case referred to medical examiner? I ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 E
Manner of Death  ☑ Natural 5 ☐ Pending ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)
Suicide 6 Could not l	28e. Place of Injury - At horr building, etc. (Specify)

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Н	espital: 1 Inpatient 2	☐ ER/Outpatient	3 🗆 [	DO
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28c.	Injury at Work?	•		
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v of	fice			I

ising n	offie 5 Hesiderice 6 Hother (Specify)
	28d. Describe how injury occurred
10	
	28f. Location (Street and Number or Rural Route Number, City or Town, State)

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Certifying F	Physician: To the best of my knowledge	e, death occurred at the time, date and place, and due t	to the cause(s) and manner as stated.					
2 Medical Exa	Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)							
and manner stated.								
		200 Liganga pumbar	20d Date signed (Month Day Year)					

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State Registrar

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egistrar's Signature

cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 🤈 🗍 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Year **Physician** 2:35 Ernest Elon Wright, Jr. June 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard 2614 Wellworth Way West Friendship 8. Date of Birth (Month, Day, Year) 06/28/1929 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) Social Security Number **Funeral** Days Hours 1 3 M 2 □ F 79 MĎ Director <u>216 24 1616</u> Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 □Yes 2XINo Director MD Howard West Friendship 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a 21794 United States 2614 Wellworth Way Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 1951-57 1 ☐ Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 2 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4or 5+) Elementary/Secondary (0-12) Salesman Tractor Equipment 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ernest E. Wright, Sr. Bertha May Sweeney ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jane Wright/Wife 2614 Wellworth Way West Friendship, MD 21794 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐Removal from State Crest Lawn Mem. Gard. 6-30-2009 Marriottsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC COLON Mouths /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760. physician a Physician/Medical as ed by the attending detached for use as IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. 9 I Inknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ♣ Residence 6 ☐ Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred ne Hospital or Attending Pin 24 hours after death.
The Funeral Director: After the Funeral Director of the funeral pletely filled in by the funeral After t 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Wedical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) within 24 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title June 29, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) As 11055 Little Prigrand Hay Colember 31. Date filed (Month, Day, Year) State JUN2 9 2009 Registrar

			e of Maryland / De	epartment of He	ealth and M	lental Hygie		22313
Physicia /Medica		1. Decedent's Name (First, Middle, Last) Richard	ID 072070700	2. Date of Dea Month June 17		th 3. Time of Death Day Year		
Examine		4a. Facility Name (If not institution, give street an 2574 Southhaven Road	d number) - LACASA		4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel	
Funeral Director		5. Social Security Number 6. Sex 1XXM 2	7. Age (In yrs. last birtho	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1) Feb 11,	Year) C	rthplace (State or Foreign country) ryland
be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, the fical Economic rotate consists.	To Be Completed by Funeral Director	1 Never Married 2 Married 1 Never Married 2 Married 3 Midowed 4 Divorced 1 Never Married 2 Married 3 Midowed 4 Divorced 15. Decedent's Education (Specify only highest grade comple Elementary/Secondary (0-12) Colle 12  17. Father's Name (First, Middle, Last)  Thomas Edgar  19a. Informant's Name/Relationship (Type. Print,	age View  Decedent Ever in U.S. deforces?  (es 2 □ No Korean or Dates:  tted)  ge (1-4or 5+)  Wood Sr.	10f. Zip Code 21401 13. Was Decedent of His If Yes, specify Cuban, 1  Yes 2  No ecedent's Usual Occupat Sive kind of work done du fe. DO NOT use retired) armer	panic Origin? (Spe, Mexican, Puerto Specify: ion ring most of working to the working most of working to the working most of working to the wo	ecify Yes or No-Rican, etc.)  ng  (First, Middle, MaLinda  al Route Number, i	Agricult  Adricult  Addition Surname)  Viola Sop  City or Town, State,	ates  derican Indian, te, etc.  White  s/Industry  cure  Der  Zip Code)
Physician /Medical		20a. Method of Disposition  1 Disposition  2 Cremation 3 Removal of Disposition 5 Other (Specify)  21. Signature of Funeral Service Licenses  23a. Part 1. Ent. The dispose, of complications to shock, or and fauly e. List only one cause Immediate Cruse (Final disease or andition resulting in death)  a.	from State  20b. Place of D cemetery, St. Bar  963  hat caused the death. Do not an each line.	isposition (Name of crematory or other place) nabas Episo 22. Name and Address Alexandria enter the mode of dying,	June 22, copal Chu copal Chu of Facility Lee Ferry Ro such as cardiac of	page 2009 archCem.T Funeral coad. Clin	Cemple Hill Home, Inc. aton, MD 2	rTown, State L1s, MD . 6633 O1d
B 点点 P	ledical Examiner	causé. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  c Du	e to (or as a consequence of)					
the death certificate by the attending physi ached for use as the t	Physician/Medi	in the past 12 months?	s, outcome of pregnancy Live birth 2□Fetal death Pregnant at time of death Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of d Month	elivery Day Year
n: The law requires that the do ficate has been signed by the r, page 2 should be detached	Completed by	Part II. Other significant conditions contributing	to death but not resulting in the			1 Yes  24a. Was an autopsy perform	24b. Were a prior to death?	
ital or Attending Physician Its after death. ral Director: After this certifi led in by the funeral director.	Medical Certification: 10 Be	27. Manner of Death  1	1 Inpatient 2 ER/Output Date of Injury (Month, Day, Year) Place of Injury - At home, farm building, etc. (Specify) To the best of my knowledge, of the basis of examination and/or manner stated.	atient 3 DOA Other ne of 28c. Injury, work? M 1 Ye , street, factory, office	4 Nursing Ho at es 2 No e, date and place,	28d. Describe how 28f. Location (Street, City or Town, and due to the cated at the time, dated	oce 6 Other (Sp. vinjury occurred bet and Number or I State)	as stated. ue to the cause(s)
ტ 5¢ \\ State Registra		30. Name and address of person who completed  A R V N D D  31. Date filed (Month, Day, Year)  JUN 2 6 2009	cause of death (Item 23a) (Ty	pe, Print) Di	GI TA	L DI	2, L1	NTHICU

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2009 **Physician** JÜNE 15, 20:21P M JEAN GOWELL WICKES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHESTER RIVER HOSPITAL CENTER CHESTERTOWN KENT Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y 9/8/1928 **Funeral** 1 □ M 2 🛣 F Months Days Hours Min 143-22-3920 80 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director X□Yes 2□No **KENT** MD CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 21620 Funeral 117 NORTH WATER STREET USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married ,o Baltimore, Maryland 21215-0036 1 □Yes 2 🛣No Specify: 2 WHITE Specify: 3 Widowed 4 □ Divorced than "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, It e Mangone. Elementary/Secondary (0-12) College (1-4or 5+) 12 ARTIST ART 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROBERT GOWELL ELEANOR PRESTON ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) R. WAVERLY W. FORD/ DAUGHTER PO BOX 115 KENNEDYVILLE, MD 21645 20a. Method of Disposition
1 Burial 2 Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 6/16/09 STEVENSVILLE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 130 SPEÉR RD. CHESTERTOWN, MD 21620 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Box 68760, attending physician Physician/Medical as the l IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. the detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð pe 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No page 2 should Completed has been Were autopsy findings available prior to completion of cause of death? autopsy certificate perform 1 ☐ Yes 2 ☑ No 2 No 1 ☐ Yes director, 25. Was case referred medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🖪 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of After 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and reanner stated. (Check only one) within 2 To the I Signature and title o 29d. Date signed (Month, Day, Year) 0 5 Name and address of person who completed cause of death (Item 23a) (Type, Print) Bldg B Chestertown 1 Patrick J. Shanahan 40 140 130 Speer 32. Registrar's Signature 31. Date filed (Month, Day, Year) State **JUN 1 6** 

Registrar

			State of Maryland / Dep	artment of Health and N <i>rtificate of Death</i>	ental Hygieı/ . <sub>Reg.</sub>	0000	00010		
			Registrar  1. Decedent's Name (First, Middle, Last)	initial of Douin	2. Date of Death	4000	3. Time of Death		
4	Physicia /Medic		ELIZABETH ANN KINSMAN WARREN			2009 Year	12:55P M		
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	ו		
			HERON POINT  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	CHESTERTOWN If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	KENT 9. Birth	nplace (State or Foreign		
	Funeral Director		225-78-3622 1 M 2 XF 90 Yrs.	Months Days Hours Min.	(Month, Day, Ye) 12/1/1918	ear) Cou	Intry) NE		
	pui w		Usual Residence of Decedent  10a, State 10b, County 10c, City, Town or Lice	ocation			10d. Inside City Limits		
	f shor	or	- CHECK	rertown			1 X Yes 2 □ No		
	28a-	Director	MD KENT CHES	10f. Zip Code	10g.	Citizen of What Cou	untry?		
	h with	al Di	205 HERON POINT	21620		USA			
	r deat	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13.	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White			
36	should be filed within 72 hours after death with the Maryland ind Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f show is martic event, the Medical Evensiaer must be natified at	by Fi	1 □ Never Married 2 □ Married   1 □ Yes 2 □ No	1 □Yes 2 X No Specify:		Specify: W	HITE		
21215-0036	2 hour	Be Completed	15. Decedent's Education 16a. Dece	dent's Usual Occupation	166	o, Kind of Business/I			
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2	led wi hygier her th			OL TEACHER		EDUCATION			
Maryland	d be fil ental H ed otl		17. Father's Name (First, Middle, Last)		e (First, Middle, Maid LELIZABET				
Ž	should nd Me mark matic	٦	CLAUDE DENNISON KINSMAN  19a. Informant's Name/Relationship (Type. Print)  19b. Mailt	ng Address (Street and Number or Ru			Tip Code)		
M	nd 2 alth a 27 is 27 is r trau		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ROBERT EVANS DR.	FAIRFAX,	VA 22031			
ore,	ss 1 a of Hei		20a. Method of Disposition 20b. Place of Disposition			c. Location - City or T	Fown, State		
<u>Ĕ</u>	Page ment ant; It ury o		1 🗆 Buriai 2 🚉 Cremation 3 🗀 Removal from State	KE CREMATION 6/10	0/09 ST	CEVENSVILL	E, MD		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once.			2. Name and Address of Facility ELLOWS, HELFENBEII 30 SPEER RD. CHES			HOME		
			23a. Part 1. Enter the disease or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between		
E.	Physician		Immediate Cause (Final disease or condition STROKE (CEREBIZOVASCULAR ACCIDENT) 24 ho						
1	/Medical Examiner		resulting in death)  Due to (or as a consequence of):			,	•		
	w	e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying						
	cuted nd ransit	Examiner	Cause (Disease or Injury that initiated events c.						
ő,	icate be executed physician and s the burial-transit		resulting in death) Last Due to (or as a consequence of):						
68760,	physic the b	edical	d						
9 X	leath certifi attending   for use as		IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deli	iverv		
P.O. Box	death e atte	Physician/M	1 DVoc 2 DNo 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year		
<u>Ч</u> О	at the I by th	hys	9 ☐ Unknown			the cause of death?			
Records,	uires that the de		Part II. Other significant conditions contributing to death but not resulting in the under the Diabet 165	ther significant conditions contributing to death but not resulting in the underlying cause given in Part I. ABETEC					
cor	w requir s been s should	lete	DEMOUTIA		24a. Was an	24b. Were au	topsy findings available		
Re	The law te has age 2 s	Completed by	DOMES OF THE		autopsy performed	prior to o	completion of cause of		
ita	Physician: The Is r this certificate ha ral director, page 2	Be C	25. Was case referred to medical	26. Place of Dea	1 ∐Yes 2 th (Check only one)	No 1 □Yes	2,400		
<u>&gt;</u>	hysic his ce	To E	examiner?  1 Yes No Hospital: 1 Inpatient 2 ER/Outpatient	nt 3 DOA Other: 4 Nursing H	ome 5 Residence	e 6 Other (Spec	cify)		
Division of Vital	ding PF h. After th funeral	Certification:	27. Manner of Death  Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  Injury  28b. Time of Injury	Work?	28d. Describe how i	injury occurred			
isi	I or Attend after death Director; , d in by the f	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide determined building, etc. (Specify)	12.00	28f. Location (Stree	et and Number or Ru	ıral Route Number.		
<u>S</u>	al or / s after al Dire	Serti	4 ☐ Homicide determined building, etc. (Specify)		City or Town, S				
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending to the Funeral Director. After this completely filled in by the funeral director, page 2 should be detached for use as	edical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deal 2 Medical Examiner: On the basis of examination and/or i and manner stated.	th occurred at the time, date and place nvestigation, in my opinion, death occu	e, and due to the caus rred at the time, date	se(s) and manner as and place, and due	s stated. to the cause(s)		
	To the within To the Comple	Me	29b. Signature and title of certifier	29c. License number		Date signed (Monti	A COLUMN TO THE PARTY OF THE PA		
	Í		ALLA Noble no	D004158		6-10-	2009		
	9		30. Name and address of person who completed cause of death (Item 23a) (Type,		ble, MD				
	2 m		122 Speer Rd. Chestertown. 31. Date filed (Month, Day, Year) 32. Registrar's Signature	MD 51950					
	Sta Registr		7 200 A Signature (World, Day, Year)	COLON INC.					

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year 2009

9:10 PM

Physician /Medical

1 - For State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

5. Social Security Number 6. Sex 1	- JC1 [1] 2 1 1 2 1							
214-42-7796 1 M 2 TF 66 Yrs. Months Days Hours Min. (Month, Days) 12-13-	Somerset  9. Birthplace (Ste	te or Foreign						
Usual Residence of Decedent  10a. State  10b. County  MD  Somerset  Eden  10e. Street and Number  3 20 20 Flower Hill Church Road  21822  11. Marital Status  1 Never Married 2 Married  3 Wildowed 4 Divorced  Fee or Dates:  15. Decedent's Education  (Specify only highest grade completed)  Elementary/Secondary (0-12)  GED  17. Father's Name (First, Middle, Last)  Theodore Holbrook  19a. Informant's Name/Relationship (Type, Print)  Cassandra Carter/Daughter  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  1 Decedent Education  1 Specify Secondary (Name of cemation)  1 Specify Secondary (Name of cemation)  1 Specify Secondary (Name of cemation)  1 Specify Specify Cuban, Mexican, Puerto Rican, etc.)  1 Tyes, Specify Cuban, Mexican, etc.)  1 Tyes, Specify Cuban, Mexican, etc.)  1 Tyes, Specify Cuban, Mexican, etc.)  1 Tyes, Puerto Rican, etc.  1 Tyes, Puerto Rican, etc.  1	10d. Insid	e City Limits						
b   MD   Somerset   Eden	1 🗆 '	∕es 2 🛣No						
	0g. Citizen of What Country?							
32020 Flower Hill Church Road 21822	J.Ş.A.							
32020 Flower Hill Church Road 21822  11. Marital Status 1 Never Married 2 Ma	14. Race - American Indian Black, White, etc.	i,						
3 TWidowed 4 □ Divorced If Yes, Give 1 □ Yes 2 □ No Specify:	Specify: Black							
15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  GED  15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired)  House Counselor	16b. Kind of Business/Industry							
Elementary/Secondary (0-12) College (1-4or 5+)	g - g - b b							
	Go-Getters Maiden Surname)							
17. Father's Name (First, Middle, Last)  Pheodore Holbrook  Madeline Spen	Ce							
19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Numbe	r, City or Town, State, Zip Code)							
Cassandra Carter/Daughter 8190 Clinton Bozman Rd, W	estover, MD 2	1871						
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Method of Disposition (Name of cemetery, crematory or other place) 20c. Method of Disposition (Name of cemetery, crematory or other place)	20c. Location - City or Town, Stat	÷						
4 Donation 5 Other (Specify) Direct Crematory. 7/6/2009	Dover, DE							
	sabella St y, MD 21801							
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory and	rest. Approxi	mate						
shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	Interval	Between and Death						
disease or condition resulting in death)  a. Due to (or as a consequence of):	1/1	/						
Sequentially list conditions b								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):								
Cause (Disease or injury that initiated events to that initiated events resulting in death) Last								
JE FEMALC:								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Live birth 2   Fetal death 1   1   Live birth 2   Fetal death 3   Ectopic pregnancy   1   Live birth 2   Fetal death 3   Ectopic pregnancy   1   Live birth 2   Fetal death 3   Ectopic pregnancy   1   Live birth 2   Fetal death 3   Ectopic pregnancy   1   Live birth 2   Fetal death 3   Ectopic pregnancy   1   Live birth 2   Fetal death 3   Ectopic pregnancy   23e Did to 1   1   1   1   1   1   1   1   1   1	23d. Date of delivery Month Day	Year						
1   Yes 2   No 9   Unknown   4   Pregnant at time of death 5   Other (specify)   9   Unknown	Mondy Buy	1041						
	bacco use contribute to the cause	of death?						
<u>1</u> □Y	es 2 <mark>⊞N</mark> o 3□ Probably 4	Unknown						
24a. Was a autop perfor		ngs available						
autop perfor 1 □ Yes								
25. Was case referred to medical 26. Place of Death (Check only or	ne)							
Pospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home   Resid	ence 6 Other (Specify)							
28d. Date of Injury at 28d. Describe h	ow injury occurred							
investigation M 1 Tyes 2 TNo	treet and Number or Rural Route	Number,						
Tablatural 5 Pending investigation 2 Accident investigation 2 Accident investigation 3 Suicide 6 Could not be determined determined determined investigation 28e. Place of Injury At home, farm, street, factory, office 28f. Location (S	n, State)							
Accident   Section   Sec								
20 Accident 3	cause(s) and manner as stated.	se(s)						
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, one and manner stated.	cause(s) and manner as stated.							
29a. Certifier (Check only one)  29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the time, date and place, and due to the time, date and place, and due to the time, date and place, and due to the time, date and place, and due to the time, date and place, and due to the time, date and place, and due to the time, date and place, and due to the time, date and place, and due to the time, date and place, and due to the time, date and place, and due to the time, date and place, and due to the time, date and place, and due to the time, date and place, and due to the time, date and place, and due to the time, date and place, and due to the time, date and place, and due to the time, date and place, and due to the time, date and place, and time time, date and place, and time time, date and place, and time time, date and place, and time time, date and place, and time time, date and place, and time time, date and place, and time time, date and place, and time time, date and place, and time time, date and place, and time time, date and place, and time time, date and place, and time time, date and place, and time time, date and place, and time time, date and place, and time time, date and place, and time time, date and place, and time time, date and place, and time time time, date and place, and time time time, date and place, and time time time, date and place, and time time time, date and place, and time time time time, date and place, and time time time time time.	cause(s) and manner as stated. date and place, and due to the cau							

State Registrar

or items mit. Pages 1 and 2 should be filed within 72 hours after artment of Health and Mental Hygiene.

crant: If item 27 is marked other than "natural", or iten inlury or other traumatic event, Ite Medical Evenines. Baltimore, Maryland 21215-0036

P.O. Box 68760, of Vital Records,

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death . 2009 **Physician** JUNE 27, 15:39 Robert. Vernon Young /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS - MEMORIAL CAMPUS CUMBERLAND ALLEGANY 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours 1 ☑ M 2 □ F 218-34-4630 Director 02/24/1938 Maryland Usual Residence of Decedent death with the Maryland 10a, State 10c. City. Town or Location 10b. County 10d. Inside City Limits s 23a or 28a-f show MD Director Allegany 11√ Yes 2 No Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 600 Frederick Street 21502 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 TXYes 2 No 1950 If Yes, Give Year or Dates: 190 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1956-1 ☐ Yes 2 ☐ No Specify: Be Completed by 3 Widowed 4 Divorced 1960 White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Supervisor Communications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Orville Lester Young Mildred Elizabeth ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith A. Young/ Wife 600 Frederick Street, Cumberland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 🛛 Burial 2 ☐ Cremation 3 ☐ Removal from State MD Vet Cem @ Rocky Gap 07/01/2009 Flintstone, MD 4 ☐ Donation 5 ☐ Other (Specify) permit.
De artm
Imp crta
any inju 21. Signature of Funeral Service License 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complic tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final excapquanatio **Physician** disease or condition resulting in death) /Medical Due to (or as a co quence of): Examiner 40 GVA( Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner pue to jor as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an rmea? 26 No 1 □ Yes 25. Was case referred to medical examiner?
1 1 Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \sum Residence 6 \subseteq Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 13:28 6/27/09FALL FROM ROOF ONTO FENCE 2 No 1 ☐ Yes 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide HOME, 600 FREDERICK STREET CUMBERLAND, MD 21502 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D34362 IMP. JUNE 28, 2009 5+ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHISHOLM, ROY, M.D., 924 SETON DRIVE, CUMBERLAND, MD 21502 31. Date filed (Month, Day, Year) JUN 30 2009 32. Registrar's Signature State Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death <sup>D</sup>2009 June 22, 4:21 Рм Samuel Anthony Young 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 07/02/1928 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days Months 1**X** M 2 □ F 579-36-3378 Washington, DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Washington 1 TYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20008 2944 Brandywine St. NW 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ∐Yes 21KL No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Calvert Commercial 5+ Real Estate Agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Eppler Samuel Young 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2944 Brandywine St. NW Washington, DC 20008 <u>Maryann Young / Spouse</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State -27-2009 Falls Church, VA National Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. 21. Signature of Funeral Service Licenses 5130 Wisconsin Ave. NW Washington, DC 20016 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final POXIA disease or condition resulting in death) Due to (or as a consequence of): Lancer Sequentially list conditions, it acase. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 2 No 1 ☐ Yes

**Physician** /Medical Examiner Examiner

**Physician** 

/Medical

10a. State

DC

Director

Funeral

Completed by

Be

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Examiner

**Funeral** 

Director

show

ed other than "natural", or items 23a or 28a-f show event, the Medical Everying must be notified at

Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, The Mance.

Pages 1 and 2 should be filed within 72 hours after death

permit.

Baltimore, Maryland 21215-0036

sician and burial-transit The law requires that the death certificate be executed attending physician for use as the buria cate has been signed by the page 2 should be detached

Physician/Medical

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Completed

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Certification: To

Medical

State Registrar 29a. Certifier

30. Name and

(Check only one)

P.O. Box 68760,

Division of Vital Records,

funeral director, After this al or Attending P s after death. Il Director: After t ed in by the funera

filled in

completely

To the Hospital or within 24 hours af To the Funeral Di

25. Was case referred to medical examiner? 1□Yes 2☑No 27. Manner of Death 1 Natural

5 ☐ Pending investigation 2 Accident 6 ☐ Could not be 3 Suicide determined 4 Homicide

1 | Inpatient 2 ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day, Year)

28b. Time of

28c. Injury at Work? 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Georgetown Rd Bethesda, MD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

TON 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

of death (Item 23a) (Type, Print)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Mary		artment of He <i>rtificate of D</i>		ental Hygie Reg.		00010
Physician			1. Decedent's Name (First, Middle, Last) Mariolina N. Zeskind					2. Date of Death Month	Day Year	3 Fime of Death
/Medical			4a. Facility Name (If not institution, give street and number)			4b. City, Town, or L	ocation of Death	0 7	4c. County of Deatl	0634 M
Examiner			PENINSULA REGIONAL MEDICAL CENTER  SA:  PENINSULA REGIONAL MEDICAL CENTER					Ì	WICOMIC	
	Funeral Director		5. Social Security Number 219–40–4304 8. See	7. Age (III	n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 06/09/194	9. Birti Con <b>42 Ma</b> i	hplace (State or Foreign untry) Cyland
	land Dw T		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	cation				10d. Inside City Limits
	Maryl a-f sho	itor	Maryland Wicomic		Salisbu					1 <b>K</b> Yes 2 □ No
	or 28	Direc	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	untry?
	s 23a	eral	28110 Van Tassel			2180			USA	
21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Madfeel Examine must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 X Married  3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1  Yes 2  No If Yes, Give Year or Dates:		Was Decedent of His If Yes, specify Cuban 1 □Yes 2 <b>X</b> No	panic Origin? (Sper , Mexican, Puerto F Specify:	cify Ye's or No- lican, etc.)	14. Race - Amer Black, White Specify:Whit	, etc.
15-0	"natui	letec	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	dent's Usual Occupat kind of work done du	tion tring most of working	g 16b	. Kind of Business/I	ndustry
212	within jiene. r than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	_	DO NOT use retired) es manage	c		clothing	3
Maryland 2	be ital	To Be C	17. Father's Name (First, Middle, Last) Mario Gentile		I	1	18. Mother's Name <b>Assunta</b>		den Surname)	
, Mary			19a. Informant's Name/Relationship ( <i>Ty</i> ) Martin Zeskind/sp		19b. Mailir <b>281</b>	ng Address <i>(Street ar</i> 10 Van Tas	nd Number or Rural Ssel Way,	Route Number, Ci Salisbur	ty or Town, State, Z Ty, MD 218	(ip Code) BO1
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other to		20a. Method of Disposition 1	emoval from State 🗜	ob. Place of Dispo cemetery, creates astern St	sition (Name of natory or other place nore of ML Cemetery	<b>}</b>		Location - City or T	·
Balt	permit. Departr Importa any inji		21. Signature of Funeral Service Lidense		22	HOTIOWAY TO SOL Snow H			ssional A y, MD 218	ssociation 04
			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only on	cations that caused the e cause on each line.						Approximate Interval Between
To be	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Non-noll		cancer				Onset and Death
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	P ±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Uniterlying Cause (Disease or injury	Due to (or as a co	nsequence of):					
	incate be executed ig physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	consequence of):						
68760,		edical E	d d							
	ertifical ing phy e as the		IF FEMALE:							
P.O. Box	The law requires that the death certific attending pare has been signed by the attending page 2 should be detached for use as to	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	3c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
۰, ص	law requires that the dass been signed by the	by Ph	Part II. Other significant conditions con	tributing to death but no	t resulting in the ur	nderlying cause given	in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
ord	equire een siç ould b							1 ☐ Yes	2 No 3 Pro	obably 4 Unknown
	The law rate has be page 2 sh	Completed						24a. Was an autopsy performed 1 Yes 2 2	prior to c death?	topsy findings available ompletion of cause of
Vit.	sician; The certificate irector, pag	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	ospital:/.		Other	26. Place of Death			
J Of	ding Phys n. After this funeral di	n: To	27. Manner of Death	1 ☑ Inpatient  28a. Date of Injury (Month, Day, Yes	2 ER/Outpatien	t 3 DOA 28c. Injury a Work?	4   Nursing Hom	e 5 ☐ Residence 3d. Describe how ir	e 6 ☐ Other (Specialist of the Company occurred	eify)
sior	tendir eath. tor: Af the fur	catio	1  Natural 5  Pending 2  Accident investigation 3  Suicide 6  Could not be	(World), Day, Tea	ar) Injury		es 2□No			
O V	l or Attenerafter death Director: I in by the	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, stre	eet, factory, office	28	Bf. Location (Street City or Town, St	t and Number or Ru tate)	ral Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical Co	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my er: On the basis of exa and manner stated.	/ knowledge, death mination and/or inv	occurred at the time restigation, in my opin	e, date and place, a nion, death occurre	nd due to the caused at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifier	and manner stated.		29c. License r		29d.	Date signed (Month	, Day, Year)
	Sail		* An			1)53	55/	-	JUNE 28	2009
	agu		30. Name and address of person who cor	, MD 10	(Item 23a) (Type, F	DS3: CARROLL	St, SA	lisbur	Y, MD.	31801
	Sta Registra		31. Date filed (Month, Day, Year)  JUN 30 21	32. Registrar's S	A A	w				

Please Type or Print in Black/Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** enne /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Seasons Hospice & Palliative Care Randallstown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** X M 2 □ F Days Months 73 08/03/1935 Director 212 34 <del>3920</del> Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Maxical Examiner mast be notified at Maryland |Baltimore 1 □ Yes 2 No Middle River Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21220 USA 618 Bowley's Quarters Road Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" not any Injury or other traumatic event. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2X No ۵ If Yes, Give Year or Dates: Specify: Specify.White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Farming 4 Farmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Augusta May Luccussen Altenburg Herman Leroy မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 618 Bowley's Quarters Road Middle River Maryland 21220 Cora Sue Altenburg 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Bayview Crematory Inc: 07/13/2009 Baltimore Maryland 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home PA 21. Signal re of Funeral Servic License 1407 Old Eastern Avenue Essex Maryland 21221 Approximate Interval Between Onset and Death 23a. Patt 1. Enter the disease, or complications that caused the shock or heart failure. List dnly one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) o cate has been signed by the page 2 should be detached in 1 Yes 2 No 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy The perform certificate 1 □Yes 2 🗆 No 2 00 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital: Other: 4 Nursing Home 5 Residence Start (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d Date signed (Month, Day, Year) cause of death (Item 23a) (Type, 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 8:01P М 2009 July 11, Louis Brusca /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2 Juliet Lane Unit 103 Nottingham Balto. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country)
 Italy 5. Social Security Number 7. Age (In yrs. last birthday) Sex Man 2□F **Funeral** 93 25,1915 December Director 220-03-2228 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be flied within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, Ite Medical Examinating the notified at 10a, State 10b. County 1 ☐ Yes 2X No Director Md. Balto. Nottingham 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21236 USA 2 Juliet Lane Unit 103 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No White Specify Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker Hot Strip Mills 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sebeastiano Brusca Loretta Pietrocarli ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Spouse 2 Juliet Lane Nottingham, Md. 21236 <u>Rose Marie Brusca</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 7-20-2009 Gardens of Faith Baltimore City, Md. 4 ☐ Donation 5 ☐ Other (Specify) Schimunek Funeral Home 22. Name and Address of Facility 21. Signature of Funeral Service Licenses ▶ 9705 Belair Rd. Nottingham. Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** yetastatio months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to infinitelate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for suils consequence off The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical the as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ě 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed Yes 2 certificate 1 ☐ Yes 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospins...
within 24 hours after deam.
To the Funeral Director: After this c 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this Certification: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and marrier as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifiei Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 7-13-2009 sallain 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

SLUASALLAM

31. Date filed (Month, Day, Year)

32. Registrar's Signature

9114 I SILLE LOG, PHILADELPHA RD NID 2123

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Day Month **Physician** 5. CO AM 2009 Ola H. Boozer 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Catonsville Catonsville Commons **Baltimore** 9. Birthplace (State or Foreign Country)
S.C. 8. Date of Birth (Month, Day, Yes 2/10/1914 7. Age (In yrs. last birthday, **Funeral** Year) Hours Min. 1 □ M 2 F **Director** 244**-1**4**-**6586 Usual Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 □Yes 2 No Director Paltimore Windsor Mill 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 7572 Merry Road 21244 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status filed within 72 hours after 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: African-American Ş. 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "na any Injury or other traumatic event, I'm Medic once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th Health Care New York City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Lirllow Boozer Mary Lake ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Odell Grant, Jr. / Nephew 2812 Brighton Street Baltimore, MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 7/14/2009 Metro Crematory Baltimore, MD 22. Name and Address of Facility Wylie Funeral Home of Balto. of Funeral Service License Co. andore 9200 Liberty Road Randallstown, Maryland 21133 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, the cause in the cause of cause of injury that initiated events resulting in death) Last Due to for as a consequence of Exami and burial-trar Due to (or as a consequence of) P.O. Box 68760; attending physician for use as the buria certificate be Physician/Medical yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Lanknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform 2 🔽 1 □ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Peath (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 N.N 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and 029 31. Date filed (Month, Day, Year) 72. Registrar's Signature State Registrar 4 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** July 11, 2009 Jean A. Bezold 6:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Transitions Health Care Sykesville 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In yrs, last birthday) **Funeral** Months Days Hours 1 □ M 2 🔀 F 214-48-0084 **Director** 1927 Maryland May 1, Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner reast be redilled at once. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 ☐ No Director Maryland Carroll Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21771 USA 4599 Roop Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates White Specify: \$ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Briel Veronica Rewuer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Daughter 4599 Roop Road; Mt. Airy, Maryland 21771 Christine Healey 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Lake View Mem. Park 7/15/2009 Sykesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Kitzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral ervice 1630 Edmondson Avenue; Catonsville 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition menha Physician /Medical resulting in death) Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) physician a s the burial-1 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy In the past 12 months? 1 ☐ Yes 2/ ☐ No Month Day Year 5 Other (specify) has been signed by the e 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 ☐ Yes 2 ☐ No 1 ☐Yes ZNo director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4- Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2₺No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To nin 24 hours after death.

the Funeral Director: After the nippletely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Division of Vital Records, P.O. Box 68760

within 2

To the I

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

and manner stated.

29c. License number

13725

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #30 per DVR g893 7/14/09 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Dav 2:20 PM KERL 2009 4c. County of Death (If not institution. BALTIMORE 8. Date of Birth 11/04/1935 1 Year | If Under 24 Hrs . Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD Social Security Number Months Days Hours Min. MD 1 □ M 2 🗗 73 219-30-7307 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County 1 ☐ Yes 2X No BALTIMORE **BALTIMORE** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3800 OLD COURT ROAD,APT. 220 21208 12. Was Decedent Ever in U.S. Armed Forces? 1 | Yes 2 | No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 XNo Specify. WHITE Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) DAVID ROSENBLATT ROSE UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) DAVID BUCKNER/SON 8107 DERBY LANE, OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ADATH YESHURUN 07/13/2009 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Liçensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) to (or as a consequence of) Days to for each consectamore of t Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 2 ₽No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Division of Vital Records, P.O. Box 68760,%attending physician for use as the buria After this certificate has been signed by the funeral director, page 2 should be detached within 24 hours after death.

To the Funeral Director: Af
completely filled in by the ful

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

Be

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MD

Funeral

Director

th and Mental Hygiene. 77 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

Department of Health ar Important: if item 27 is any injury or other trau

Physician

/Medical

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

the Maryland

Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examine IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Be Completed 25. Was case referred to medical examiner? 1∐ Yes 2 Tho Certification: To 27. Manner of Death 1 -Natural 5 Pending investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year)

29c. License number

To the

State Registrar

Lamont C. Smith, MD 22 S. Green St. Baltimore, MD 31. Date filed (Month, Day, Year)

29b. Signature and title of certifie



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. park

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month Physician Dora Emma Caputo July 2009 5:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Manor Health Care Center Cecil Rising Sun Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🔀 F Director 137**-**30-9952 85 June 26, New Jersey Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" --- any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Maryland Cecil Rising Sun 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1881 Telegraph Road 21911 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Guidance Counselor Public Schools 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Floyd J. Buss Edith M. Sprague 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 542 Grant Avenue, Collingswood, NJ 08107 Francis G. Caputo Jr./ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 7-13-09 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A. Dec 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical or as a consequence of): boputusio Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Division or Vital Records, P.O. Box 68760, 经 Physician/Medical IF FEMALE: 23c. If ves, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 menths?
1 □ Yes 2 ☑ No 23d. Date of delivery 2 Fetal death 3 □Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the a 9☐Unknown g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Whiknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe 2 1 No 1□ Yes 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: ဥ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this s after death.

I Director: After this of in by the funeral d 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

10 State Registrar 29b. Signature and title of certifier

an 31. Date filed (Month, Day, Year JUL 1 4 2009

M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Vh D

29d. Date signed (Month, Day, Year) 7/13/0°

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1845PM

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Month

29d. Date signed (Month, Day, Year)

Day

1 Yes 2 No

GEORGIA

State Registrar DHMH 17 Rev 1/2001 29a, Certifier

(Check only one)

Justin

29b. Signature and title of certifier

Medical

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

00069021

SINAI HOSPITAL OF BALTIMORE 2401 W. BELVEDEIZE AD 21215

		•	1 - For State Registrar	State of Marylan		artment of H			iene g. No. 009	22327
	Physici		1. Decedent's Name (First, Middle, Last	Car	ter			2. Date of Death		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	TOWN			IMORE		4c. County of Dea	
Fo.	Funeral Director		5. Social Security Number  6. Security Number  214-24-8021  Usual Residence of Decedent	7. Age (In yrs. 1	Vre	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, DEC . 2	Year) C	thplace (State or Foreign ountry) ARYLAND
pelveMedia	or 28s-f show a notified at	Director	10a. State         10b. County           MARYLAND         N/A           10e. Street and Number	10c. Cin	y, Town or Lo	Cation  TIMORE  10f. Zip Code		10	0g. Citizen of What C	10d. Inside City Limits 1 ☑ Yes 2 ☐ No ountry?
d 21215-0036 filed within 22 hours after death with the Manyland	nial Hygiene.  event, the Medical Examinat must be notified at	by Funeral	560 GOLD STREET  11. Marital Status  1 Never Married 2 Married  *XXWidowed 4 Divorced	12. Was Decedent Ever in U. Amed Forces? 1	1	212. Was Decedent of Hi. f Yes, specify Cubar		pecify Yes or No- Rican, etc.)	U.S.A.  14. Race - Am Black, Whi	
Maryland 21215-0036	Hygiene. other then "natu	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 8th grade		(Give	tent's Usual Occupa kind of work done d DO NOT use retired,	uring most of work	ing	16b. Kind of Business	/Industry
iryland Hould be file	la d	To Be (	17. Father's Name (First, Middle, Last)  CHARLES BUTLER  19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Address (Street a	ELIZZ	e (First, Middle, M ABETH YOU ral Route Number,		Zip Code)
altimore, Ma	lealth a		Charlotte Carter  20a. Method of Disposition  1 \( \begin{array}{c} \text{Burial} & 2 \subseteq Cremation & 3 \subseteq 1 \\ & \text{Donation} & 5 \subseteq \text{Other} & (Specify	20b. P Removal from State	lace of Dispo emetery, crer	Gold Strestion (Name of natory or other place		Date 2	Maryland 2 20c. Location - City o	Town, State
Balti			21. Signature of a sale sale sale sale sale sale sale sa	40um	W.	. Name and Addres	s of Facility BROWN COL	MUNITY E	FUNERAL HO	
8760,	hysician and burial-transit sthe purial-transit	dicai Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, any, bearing to inhediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	uence of):  ON OL	er the mode of dying	g, such as cardiac	or respiratory arre	sst.	Approximate Interval Between Onset and Death
O. Box 6	e attending d for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	I death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
Records, P.O	been signed b	Ď	Part II. Other significant conditions co	ontributing to death but not res	ulting in the u	nderlying cause give	on in Part I.			to the cause of death?
		Completed	•	205					y prior to death? death? 1 ☐ Ye	utopsy findings available completion of cause of
Division of Vita	h. After this funeral di	ation: To Be	27. Manner of Death  1 Matural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	28c. Injury Work	r: 4 Nursing H		el nnce 6 Other (Sp w injury occurred	ecify)
		Certification;	3 Suicide 6 Could not be determined	building, etc. (Specify	y)			City or Town		
JO Districted of	within 24 hours after	Medical	29a. Certifier (Check only one)  2	vsician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, deat tion and/or in	occurred at the tim vestigation, in my op 29c. License	pinion, death occur	rred at the time, da	ause(s) and manner a ate and place, and du 9d. Date signed (Mor	e to the cause(s)
1	->=0		30. Name and address of person who d	completed cause of death (Item	n 23a) (Type,	Print)	3912	7	7/13/0	9
	Sta Registr		31. Date filed (Month, Day, Year)  JUL 14 20	MEI) 82   32. Peģistrar's Signa	A L	celou	) ST "	rull	noel	MD 2120)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2 1 1 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 13, 2009 **Physician** Anna Katerina Clookie 12:50P <sup>M</sup> July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Manor Care Towson Towson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Yrs July 25, 1929 216-56-3101 Germany Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-1 shov any Injury or other traumatic event, the Medical Examiner must be notified at 1 □Yes 2□No Director Maryland Baltimore Towson 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 509 East Joppa Road 21286 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after a ealth and Mental Hygiene. n 27 Is marked other than "natural", or ite 1 ☐ Yes **XX** If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2**XX**No Specify: þ Specify: White 3 XXWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Assistant Manager Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) To Be Johan Beslmisl Babette Koeppel 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wm Edward Herbold Jr Son 415 St Mary's Road Pylesville, Maryland 21132 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Loudon Park Cemetery July 16, 2009 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc Signature of Funeral Service Licensee 6500 York Road Baltimore, Maryland 21212 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 20 years **Physician** disease or condition resulting in death) Stroke /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last certificate be execu Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division or Vital Records, P.O. the Hospital or Attending I hin 24 hours after death, the Funeral Director: After within 24 hours a To the Funeral D

Registrar

State

29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Houk

JUL 1 4 2009

and manner stated.

402 York Rd

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Towson MD 21204

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>y</sup> 2009<sup>Year</sup> **Physician** Day July 10, Leslie Collins Manley 3:04 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Greater Baltimore Medical Center Baltimore Towson f Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) X□M 2□F Days Hours 234 44 3318 80 Director 09/06/1928 West Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Worldon Event has must be mailthed at Maryland Baltimore Essex Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 432 Delaware Avenue 21221 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc filed within 72 hours after 1 Never Married 2 Married If Yes, Give Year or Dates: 1 ☐ Yes 2X No Be Completed by Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Machinist Manufacturing Company Maryland .. Pages 1 and 2 should be file tment of Health and Mental H tant: If Item 27 Is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carl E. Collins ည Winona Tanzey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Collins (son) 7220 Gunpowder Road Middle River Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page Department c Important: If any injury or injury or Marial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gardens 7/14/2009 Middle River Maryland 4 Donation 5 ☐ Other (Specify) 21. Signa of Funeral Service Cicensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 old Eastern Avenue Essex Maryland 21221 complications in a caused the deam. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. nter the disease, or or heart failure. List Part 1 shock Imme tate Lause (Final **Physician** pneumon /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month by the a 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has e 2 s 24a. Was an rector, page 2 autopsy performed 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 TNo 1 Inpatient this Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hou To the Fune completely fi Medical (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

29c. License number

29d. Date signed (Month, Day, Year)

Charles St Suite 550 Towson MD 21204

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GOSME

			1 - For State Registrar		State of M	ar yrarii	Cei	tificate of	nealli Deati	h and Me	епіаі пу	giene Reg. No		UJ	L. L.	33
	Physici	an	1. Decedent's Name (First, I	Middle, La	st)		-			2	2. Date of De	ath Da	av	Year	3. Time o	f Death
	/Medi		George Steve								July 1	2th	, 200	9	8:10	A M
	Examir	ner	4a. Facility Name (If not insti		,			4b. City, Town, o					. County o			
تمميد			5807 Seminole  5. Social Security Number	6.5		10 (In ure le	ast birthday)	Berwyn If Under 1 Year	_		B. Date of Bir		rince		rge's	or Foreign
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21215-0036	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Expriner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ 3 □ Widowed 4 □ Divo		12. Was Decedent Armed Forces? 1			Was Decedent of h fYes, specify Cub I □Yes 2 XNo			ify Yes or No can, etc.)	)-		, White, e	ean Indian, etc.	
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and	e d ala	Be	17. Father's Name (First, Mid		1					ther's Name (		, Maider	n Surname	9)		
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Maryland	s 1 and 2 should if Health and Mer item 27 Is marke other traumatic		19a. Informant's Name/Rela					g Address (Street					,		,	
	is 1 and 2 of Health item 27 li		Milagros I.  20a. Method of Disposition	vega	- wire	20b. Pl		Seminole sition (Name of natory or other place		. berv	vyn He		ocation - 0			
Baltimore,	Page: nent o ant: If		1 🗷 Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth					natory or other pla 11 Cemete					tlan	,	,	
Ball	permit. Departr Imports any Inju		21. Signature of Funeral Ser	vice Licer	see lle		Ma Ma	Name and Address arshall s 308 Suit	ss of Fac	neral F	Home of				6	
			23a. Part 1. Enter the diseas	e, or com	plications that cause	the death.							rib.	20741	Approxima	te
No.	Physician		shock, or heart failure. Immediate Cause (Final disease or condition	List only	one cause on each i		asis								Interval Be Onset and 6mont	Death
	/Medical		resulting in death)		Due to (or as											
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687	ficate pphysis the	edical			d											
O. Box	that the death certined by the attending detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	t 📆	23c. If yes, outcome 1  Live birth 4  Pregnant a 9  Unknown	2 Fetal	death 3 □	] Ectopic pregnanc ] Other <i>(specify)</i> _	у				23d. Date Mon			Year
О,	w requires that s been signed b should be deta	by Pr	Part II. Other significant con	nditions c	ontributing to death b	ut not resul	Iting in the ur	derlying cause giv	en in Par	t I.	23e. Did t	tobacco	use contri	bute to th	ne cause of	death?
ğ	requires seen sign hould be										1 🗆	Yes 2	<b>⊠</b> No ∶	3∏ Prob	ably 4 🗌	Unknown
သွ	@ # N	Completed									24a. Was		24b. W	ere auto	psy findings	available
Ě	m — Φ	E O									autoj perfo 1 □ Yes	rmed?	de	rior to coi eath? □Yes	mpletion of	cause or
'ita	ysician: The is certificate director, pag	Be C	25. Was case referred to me examiner?	dical					26. Pla	ce of Death (	1		-		2 23/10	
<u></u>	ys dir	2	1 ☐ Yes 2 ☐XNo		Hospital: 1 ☐ Inpatio	ent 2 🗆 E	ER/Outpatien	t 3 □ DOA Oth	er: 4 🗆 I	Nursing Home	e 5⊠ Resi	dence	6 □Othe	r (Specif	y)	
n O	ng fter	ë.	27. Manner of Death 1 ANatural 5 □ Pe	ending	28a. Date of Inju (Month, Da	iry y, Year)	28b. Time of Injury	28c. Inju	y at k?	28	d. Describe	how inju	ry occurre	d		
sio	Attending r death.  ector: After by the fune	cati	2 ☐ Accident inv	estigation ould not be					Yes 2[							
=	tal or At s after or al Direct ed in by	Certification:		termined	28e. Place of Inj building, et	ury - At hor c. <i>(Specify</i> )	ne, tarm, stre )	eet, factory, office		28	f. Location ( City or To	Street ar wn, State	nd Numbe e)	r or Rura	il Route Nur	nber,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (	29a. Certifier 1 ☑ Cert (Check only 2 ☐ Med	ifying Ph ical Exan	ysician: To the best niner: On the basis o and manner st	of examinati	vledge, death ion and/or inv	occurred at the ti restigation, in my o	me, date	and place, and leath occurred	nd due to the d at the time,	cause(s date an	s) and mai d place, a	nner as s	tated. the cause(	s)
	To the within 2 To the comple	Σ	29b. Signature and title of ce	rtifier	1			29c. Licens	e numbe	r		29d. Da	ate signed	(Month,	Day, Year)	
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	AI		30. Name and address of pe													
	- C'		Linda Burrel 31. Date filed (Month, Day, )			Inives		Lvd. #400	) Wh	neaton,	MD.	2090	02			
	Sta Registr		JUL		009 Sene		8. 4	all								

DHMH 17 Rev 1/2001

Division of Vital Records, P.O. Box 68760,

09-05383	
Rosalind Duvall	

Rosa	alind Duvall		State of Maryland / I-For State Registrar	Department of Certificate of		and N	/lental H		Reg. No	. 200	The last to the
Mari	Physici		1. Decedent's Name (First, Middle,Last)					Date of De     Month	Day	/ Year	3. Time of Death 0719 hrs
vie	dical Exami	ner	Rosalind Cynthia Duvall 4a. Facility Name (if not institution, give street and number)	17	b. City, Town	2 01 100	ation of Death	July 9, 2		4c. County of Death	
			3461 Carriage Hill Drive	1	Randalls		ation of Deat	•		Baltimore Cou	
	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1	Year I	f Under 24Hr	s. 8. Date of E	Birth (M!	M/DD/YYYY) 9. Bir	thplace (State or
	Director		212-84-5275 1 M 2 XF	52 Yrs.		Days	Hours Mir	07/07	/105	7 Foreig	on untry) MD
			Usual Residence of Decedent	32 110.				0//0/	/ 1 55	/	· InD
	any		10a. State 10b. County	10c. City, Town or Locati	on						10d. Inside City Limits
	and show nce.	٥	MD Baltimore	Randalls	stown						1 Yes 2 No
/	Maryl 28a-1 d at o	rect	10e. Street and Number		10f. Zip Coo	de			10g. C	Citizen of What Cou	ntry?
)	h the	ā	3461 Carriage Hill Circle		211				US		
	5-0036  ed within 72 hours after death with the Maryland tygiene. other than "natural", or items 23a or 28a-f show any the Medical Examiner must be notified at once.	Funeral Director	11. Marital Status  1 X Never Married 2 Married Armed Forces?		s Decedento es, specify C			pecify Yes or No Rican, etc.)	<b>N</b> 0-	14. Race - Amer White, etc.	ican Indian, Black,
	er dea		3 Widowed 4 Divorced If Yes, Give Year	X No	Yes 2 🏋	No sr	necifir			Specifica C	
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	5-0 led wi Hygie other		17. Father's Name (First, Middle, Last)			18.1	Nother's Nam	e (First, Middle	, Maide	en Surname)	
	121 I be fi ental arked vent,	Be	Raymond W. Divall	1		<u>F</u> ]	eanor R	Johnson	n	<u> </u>	
	D 2 should and M 7 is m	7	19a. Inf. rmant's Name/Relationship (Type, Print )							City or Town, State	
	and 2 ealth : em 2 em 2 iraum		Eleanor R. Duvall / Mother  20a. Method of Disposition	20b. Place of Dispos				Date		11s, MD_211 c. Location - City or	
	Imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. I fitem 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 Cremation 3 Removal from Star	crematory or oth		Con	-i 7	/15/2000	,	Timoniam N	n
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Imperiant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other Specify:	Dulaney Val						Timonium, M	
	Ba Perm Depa Imm	į (g	2 1	000	OO T *1	1 033 011	Wy1	ie Funera	al Ho	omes P.A. o	f Balto. Co.
	Physician	4	23a. Part I. Enter the disease, or complications that caused to	he death. Do not enter the	ne mode of dy	ying, suc	020 R20 h as cardiac	or respiratory a	arrest, s	shock, or heart	Approximate Interval
	/Medical		failure. List only one cause on each line.  Immediate Cause (Final disease a. <b>Hypertens</b> )	ive cardiova	ascula	r di	sease				Between Onset and Death
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	876 tificat ng ph as the	sician/M	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcom		tal death	3	Ectopic pregn	ancy	ľ	23d. Date of deliver Month	y Day Year
	th cer trendi	icia	past 12 months?  4 Pregnant at t		her (Specify)						
	Bo he dea the a	Phys	1 Yes 2 No 9 Unknown g Unknown				1. 5. (1)	22- Di-			the cause of death?
	P.O that t	by F	Part II. Other significant conditions contributing to death			use give	nın Pantı.				bably 4 V Unknown
	ts, l quires en sig uld be	ted	Mental retardation; set	tzure atsore	ier			24a. Wa			utopsy findings available
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	of V; Phys ter thi eral di	유	1 V Yes 2 No Impatter  27. Manner of Death 28a. Date of Injur			. Injury a				injury occurred	
	on C anding arth. r: Af	fio	1 X Natural 5 Pending (Month, Day,Ye	ear)	1	Yes	2 No				
	/iSic r Atte ter des irecto n by t	fica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Inj	ury - At home, farm, stree	et, factory, off	fice build	ling, etc.				ural Route Number, City
	Divital o	Certification:	4 Homicide determined (Specify)					or Town	i, State)	)	
	Hosp 24 ho Func etely f		29a. Certifier 1 Certifying Physician: To the best of my	-							
- ,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial _ transit	Medical	one) 2 Medical Examiner: On the basis of exam and manner stated.	nination and/or investigat				at the time, da			
_	. , , ,	Σ	29b. Signature and title of certifier			cense ni	0.0	AE		d. Date signed (Mo	onth, Day, Year)
			Theodore M. Kix J.	num.		).C.M.I	<u>=</u> . 0C	a i E	Ju	uly 10, 2009 	
			30. Name and address of person who completed cause of de	eath (Item 23a) edical Examiner	111 Don	Stron	t Raltima	re, MD 212	n1		
		tota	Theodore M. King, Jr., MD. Assistant Me 31. Date filed (Month, Day, Year) 82. Registrar	's Cinneture A		101166	ic, Daiuiii0	10, IVID 212	.0 1		
	S Regis	tate trar	IIII 1 4 2009 America	S. Signature	/						

Box 68760, P.O. Division of Vital Records,

(Check only one)

29b. Signature and title of certifier

State Registra and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c, License number

52326

29d. Date signed (Month, Day, Year) May 19, 2009

20912

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2009 Dav Month **Physician** /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner JIChris Kaltimore IOWSON HOSPICE 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs, last birthday) **Funeral** Yea 1 □ M 2 🛂 Months Days Hours Min 218-52-0135 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at **Funeral Director** timore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2121 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐Yes 2 Notes: If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Id 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be iones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 siment of Health an 3803 Wa permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tra 500 EVIC alto. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Surial 2 ☐ Cremation 3 ☐ Removal from State altimore 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or espiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician mil Neck CHNCER disease or condition resulting in death) A 0 /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. nding physician ause as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) 1 ☐Yes 2 ☑No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Tes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) 5 Residence 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 ☐ Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated

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within 24 hours a

To the Funeral

Registrar

State

29b. Signature and title of certifie

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31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

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6701

Registrar's Signature

amend #17&18 Per Fit G893 7/20/09 JH State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Patricia Μ. Donaho 2009 Ju<sub>1</sub>y 8:30 a 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Mercy Ridge Timonium If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 □ M 2 🛛 F Months Days Director 213-26-7754 80 July 8, 1929 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be not lived at 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 Funeral 2525 Pots Spring Road Apt 312 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2★ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 X No á If Yes, Give Year or Dates: Specify Specify: 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5 +Analyst State Dept of Health 18. Mother's Name (First, Middle, Maiden Surname)
Hortense Maryland 17. Father's Name (First, Middle, Last)

Joseph A.

-Unknown Be Maquire **Unknown** Lucy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Piendak 3401 Greenway Apt. 202 Friend Baltimore, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Ser 7/11/09 Hampstead, MD 22. Name and Address of Facility 11824 Reisterstown Road 21. Signature of Funeral Service Licensee Ste her M ELINE FUNERAL HOME Reisterstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** thma Die lo (or as a consequence of): /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Errier underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ. Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑(No 24a. Was an certificate has autopsy performed? 1 Yes 2.2000 Division of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation in 24 hours are.
the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 2 To the and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) Z004 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) ERNESTINE WRIGHT, M.D. 2300 DULANEY VALLEY ROAD 21093 TIMONIUM MD31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

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Death

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PATRICIA

DONAHO,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vear **Physician** Clara Agnes Perrie Evans <u>6:0</u>0 ₽<sup>M</sup> July 10 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert 3460 St. Leonard Road Port Republic If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday, **Funeral** Months Days Hours Min 1 □ M 2 🛛 F 72 Maryland Director 213-38-3834 8/26/1936 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f shov 27 Is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Calvert Port Republic MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3460 St. Leonard Road 20676 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 ☐Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 M Married altimore, Maryland 21215-0036 1 ☐Yes 2 X No Specify Specify: White ş 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Certified Nursing Assistant Medical permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked ofthe any injury or other traumatic event, 2008. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cora Agnes Curtin Louis Bradley Perrie ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3460 St. Leonard Road, Port Republic, MD 20676 Ellen Dube/ Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry 7/14/2009 Hanover, MAryland 4X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Septice Licens 01 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) CYE /Medical Due to (or as a consequence of) Examiner G Sequentially list conditions, if any, leading to ininiediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 ₩ No 1∐Yes 2∐No 1 □ Yes 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗀 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

State Registrar 31. Date filed (Month, Day, Year)

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Yazdani M.D.

30. Name and address of person who completed cause of dealth (Item 23a) (Type, Print)

29b. Signature and title of certifier

egistrar's Signature

Acron

29d. Date signed (Month, Day, Year) 0

29c. License number

			For State Registrar	State of Mar		artment of F			giene Reg. No.	009	22336
1	Physici	an	1. Decedent's Name (First, Middle, L Jerry	ast) Demont	Eisenh	ord+		2. Date of Dea Month July	Ph.	.0°0°9	3. Time of Death 10:10P M
	/Medic Examin		4a. Facility Name (If not institution, g	ive street and number)	LISER		r Location of Death		4c. County	of Death	
	Funeral Director		218-44-5494	Sex 7. Age (	In yrs. last birthday	Months Days	Hours Min.	8. Date of Birt (Month, Da May 22	th (Par) 46	9. Birthp Cour	place (State or Foreign htry) MD
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Evanther must be notified at once.	Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County  MD Anne Ar  10e. Street and Number  407 Baltic Aven  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's (Specify only highest g  Elementary/Secondary (0-12)	unde1  12. Was Decedent Event Armed Forces? 1 [X]Yes 2 □ No If Yes, Give Year or Dates:	16a. Dec (Giv life.		Specify: pation during most of work d)	pecify Yes or No Rican, etc.)	Specif	What Cour ce - Americ ck, White, y: Whi	can Indian, etc. Le
yland 2	ruld be filed Mental Hyg arked other attc event, I	To Be C	17. Father's Name (First, Middle, Las George William	,			18. Mother's Nam	ne (First, Middle, Lary Max		ne)	
, Mar	and 2 sho ealth and I n 27 is ma ner trauma	·	19a. Informant's Name/Relationship Mrs Joan Eisenh	ardt/Wife	407	ing Address (Street Baltic A	venue Gl		e, MD 2	1061	
ltimore	it. Pages 1 intment of H rtant: If iter njury or oth		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3   4 ☐ Donation 5 ☐ Other (Spec	ity Entombment	Cedar Hi	osition (Name of matory or other place 11 Cemete	ry 20	09	Brookly	n Pa	rk, MD
Ba	perm Depa Impo any le		21. Signature of Funeral Service Line 23a. Part 1. Enter the disease, or con-	- No	NZ S	2. Name and Address PA ervices l	2nd Ave	.SW Glen	Burnie		21061
8760, d.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit of page 2.	lical Examiner	shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a c	eonsequence of):  PROCIFE	RATIVE		MIA	_		Approximate Interval Between Onset and Death  5 MowThy  2 Y EARS
P.O. Box 68	the death certific y the attending p ched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnand	cy .			ite of deliver	ery Day Year
	quires that en signed b uld be deta	ğ	Part II. Other significant conditions	contributing to death but r	not resulting in the o	underlying cause giv	ren in Part I.		obacco use con ⁄es 2 □ No		he cause of death?
Division of Vital Records,	: The law re cate has bee page 2 sho	Completed						24a. Was autop perfor 1 □Yes	rmed?	Were auto prior to co death? 1 ☐ Yes	ppsy findings available impletion of cause of 2  No
of Vita	hyslclan his certif I director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient	2 ER/Outpatie	nt 3 DOA Oth	26. Place of Dea er: 4 \( \text{Nursing H} \)	th (Check only o		ner (Specia	(y)
sion o	ending P eath. or: After t the funera	Certification:	27. Manno of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not		(ear) 28b. Time of Injury	Wor	ry at k? IYes 2 □ No	28d. Describe h	now injury occur	red	
Divi	ital or Att urs after d ral Direct	Certifi	4 ☐ Homicide determined	building, etc. (				City or Tov	vn, State)		al Route Number,
	he Hosp in 24 ho he Fune pletely f	ledical	29a. Certifier 1 ✓ CertifyIng F (Check only one) 2 ✓ Medical Exa	hysician: To the best of r miner: On the basis of ex and manner stated	camination and/or i	th occurred at the ti nvestigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and m date and place,	anner as s	stated. the cause(s)
	Voith To t	Σ	29b. Signature and title of certifier	02-	-	29c. Licens	6559		29d. Date signe		
	20+1		30. Name and address of person who	completed cause of deat	h (Item 23a) (Type	Print)					
	Sta Registr		31. Date filed (Month, Day, Year)	3. Registrar's	Signature	New .	(1)-10				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Forbes Charles 0630 M July UΓ 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 - F Director 90 215-16-7479 March 8, 1919 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No Director Baltimore Reisterstown 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 108 Nob Hill Park Drive 21136 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc 1 ☐ Never Married 2 😿 Married 1 X Yes 2 [ If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Reisterstown Lumber Co Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles A. Forbes, Sr. Edith Palmer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paulette F. Forbes Wife 108 Nob Hill Park Drive Reisterstown, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Evergreen Memorial Pk 7/16/09 Finksburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road ELINE FUNERAL HOME Reisterstown, MD 21136 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between hock, or heart failure. List only one cause on each line. Onset and Death Imm/ diate Cause (Final **Physician** Pulmonary time ase or condition resulting in death) /Medical Examiner middle cerebral artery Strole Sequentially list conditions, frequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events southing in death). Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy completely filled in by the funeral director, page 2 should be detached for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 4 No 1 TYes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Impatient Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA မှ within 24 hours after death.

To the Funeral Director; After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 Yes 2 No 2 ☐ Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 296. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PLI mD D67406 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hoese mo PhD 600 North Wolfe St, Baltimore, MD, 21287 ict 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

9-05461 cott Alvin Fontai			partment of Health and Mer		ible. 20(	)9 2233
Physicia: al Examinی	n/	edistrar I. Decedent's Name (First, Middle,Last) Scott Alvin Fontaine	Certificate of Death	Date of Death     Month	Day Year	3. Time of Death 1315 hrs
al Lamin		4a. Facility Name (if not institution, give street and number) 29449 Charlotte Hall Road	4b. City, Town, or Location Charlotte Hall	July 12, 20	4c. County of Deat St. Mary's	1
Funeral Director		229-09-120 1XM 2 F	rs. last birthday) If Under 1 Year If Under 3 Year If Under 3 Year If Under 4 Year If Under 5 Year If Under 5 Year If Under 5 Year If Under 6		` C	rthplace (State or Foreign ountry) VA
and Fshow any		MD Prince George (	City, Town or Location  Oxon Hill			10d. Inside City Limits  1 Yes 2 X No
death with the Maryland or items 23a or 28a-f show must be notified at once.	I Director	10e. Street and Number 233 Panorama Dr. 29449 Harlotte Hall Road			g. Citizen of What Cou USA	
IMOTE, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Menial Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married 12. Was Decedent Ever Armed Forces?  1 X Yes 2 N  3 XWidowed 4 Divorced If Yes, Give Year 1 9 4 2	If Yes, specify Cuban, Mexica  1 Yes 2 No specify	n, Puerto Rican, etc.)	SpecifyAme:	
036 nithin 72 hours ene. rr than "natur Medical Exam	Completed I	15. Decedent's Education (Specify only highest grade complete  Elementary/Secondary (0-12)  College (1-4 or 5+)  4	during most of working life. DO NO	Γuse retired)	US Post	
1215-0 d be filed w lental Hygie narked othe	Be Co	17. Father's Name (First, Middle, Last) Watson Hale Fontaine		er's Name (First, Middle, Midd	r	to Zin Code)
, MD 2 and 2 shoul ealth and M em 27 is m	٩	19a. Informant's Name/Relationship (Type, Print)  Scott A. Fontaine, Jr./So 20a. Method of Disposition				20747
Baltimore, permit Pages I a Department of He Important: If ite Important: If ite			rematory or other place) Mayo Miss.Ch.Cem.		Ridgeway	
Physician		23a. Part f. Enter the disease, or complications that caused the d	22. Name and Address of Facil 5126 Belair eath. Do not enter the mode of dying, such as			Approximate Interval
'Medical ∡aminer		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Atherosclect Due to (or as a consequer	ortic cardiovascular dice of):	disease		Between Onset and Death
or ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequer d.	nce of):			
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ath o atten or us	siciar	25c. If yes, outcome of past 12 months?  1 Yes 2 No 9 Unknown  25c. If yes, outcome of 1 Live birth 4 Pregnant at time 9 Unknown	2 Fetal death 3 Ector	oic pregnancy	Month	Day Year
P.O. I res that the signed by the be detached	d by Phy	Part II. Other significant conditions contributing to death but Pneumonia	not resulting in the underlying cause given in I			to the cause of death?
Records The law requi cate has been	Completed			24a. Was autop perfoi 1 🗸 Yes	sy prior to med? death	
Vital   ysician: his certiff director,	o Be (	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient	Othor	h (Check only one)  Nursing Home 5	Residence 6 🗸 Otl	her: Scene
on of cending Pheath.  or: After the funeral	tion: T	27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation  28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury at Wo		now injury occurred	
Divisior pital or Attend ours after death teral Director: filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify)	At home, farm, street, factory, office building,	etc. 28f. Location (\$ or Town, \$		Rural Route Number, City
To the Hospital within 24 hours To the Euneral completely filled	Medical (	one) 2 Medical Examiner: On the basis of examinar and manner stated.		occurred at the time, date	and place, and due to	the cause(s)
	Σ	29b. Signature and title of certifier  August May 1990 30. Name and address of person who completed cause of death	29c. License number O.C.M.E.	er	29d. Date signed (I	viontn, ∪ay,Year)
ohorad		Pamela E. Southall, MD Assistant Medical	Examiner 111 Penn Street, Balt	imore, MD 21201		
St Regist	tate trar	31. Date filed (Month 1974), Yari 4 2009 32. Figistrar's S	gnature facel			

		•	For State Registrar		Ce	rtificate of	Death		Reg. No.	2009	22339	
Н	Physicia	an	1. Decedent's Name (First, Middle, Las					2. Date of D Month	Day		3. Time of Death	
Š.	/Medic	al	ANNA E		FIEDLEF		r Location of Death	July	09	2009 County of Death	10:00 A M	
)	Examin	er	4a. Facility Name (If not institution, given St. Joseph Nursine)			Catonsvi				altimore		
8.	Funeral Director		5. Social Security Number 6. S 217–05–7714 1		(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B	irth 1914	Cot	place (State or Foreign intry) Land	
	and w t		Usual Residence of Decedent  10a. State 10b. County	1	I 0c. City, Town or Lo	ocation					10d. Inside City Limits	
	Maryl I-f sho fied a	tor	Maryland Baltimo	re	Woodlawn						1 ☐Yes 2 ☐ No	
	h with the	al Director	10e. Street and Number 6431 Gilmore Stre	et		10f. Zip Code 21 207	-			izen of What Col ed State		
	r deat lems 2	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or N Rican, etc.)	0-	14. Race - Amer Black, White		
920	urs afte al", or if Examin		1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2X No If Yes, Give Year or Dates:		1 ☐ Yes 🎎 No	Specify:			Specify: W	nite	
2	72 ho 'natur dical E	eted	15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	oation during most of work	king	16b. K	ind of Business/l	ndustry	
21215-0036	within ene. than "	Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	) <u> </u>	DO NOT use retire: Intant	d)		Ret	ail Dept	. Store	
land 2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	To Be Co	17. Father's Name (First, Middle, Last, Thomas Harrington				18. Mother's Nam Sallie H		e, Maiden	Surname)		
, Maryland	and 2 shou alth and N 127 Is mar er traumat		19a. Informant's Name/Relationship ( Barbara Cronin /	**	6431	ng Address (Street Gilmore S	Street Wo		-			
Baltimore,	ges 1 s t of He if Item or othe		20a. Method of Disposition  XXBurial 2 Cremation 3	Removal from State	20b. Place of Disponentery, cre			Date		ocation - City or		
<u>=</u>	artmen artmen artant: njury		4 □ Donation 5 □ Other (Specification of Funeral Service in Servi	9	Woodlawn					lawn, Ma	aryland al Homes PA	
Ba	perm Depa Impo any i		Of Anniel.	Mohn		1 S. Ches						
ı	93		23a. Part1. Enter the diseas or comshock, or heart failure. List only	plications that caused to one cause on each line	ne death. Do not en	ter the mode of dyi	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death	
Š,	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. The	umm,	•					Onset and Death	
	Examiner				consequence of):							
	red isit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury	Due to (or as a	consequence of):							
Ć.	rtificate be executed ng physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):							
68760,	ate be	Medical		_d								
.O. Box 6	eath ce attendii for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{No} \) No 9 \( \text{Unknown} \) Unknown  23c. If yes, outcome pf pregnancy 1 \( \text{Live birth} \) 2 \( \text{Fetal death} \) 4 \( \text{Pregnant at time of death} \) 5 \( \text{Other } \( (specify) \)							23d. Date of delivery Month Day Year		
Δ.	w requires that the de been signed by the s should be detached	by Ph	Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause giv	ven in Part I.	23e. Dio	tob <i>a</i> cco	use contribute to	the cause of death?	
ord	require een sig	ted I	Whypml in	er yong	pusti.	re mo	Mouse				obably 4 Unknown	
Records,	he law has b ge 2 st	Completed	Den inter	2 2 1 12	- (			24a. Wa au pe	topsy normed?	prior to death?	topsy findings available completion of cause of	
Vita	an: T	Be Co	25. Was case refe -d t -dical	n 0389 W	nly.		26. Place of Dea	1☐ Yes ath (Check only	_	o 1 □Yes	2□ No	
	hysici his cer Il direc	To B	examiner? 1 ☐ Yes 2D No		t 2 ER/Outpatie	III JU DOA		1		6 ☐Other (Spe	cify)	
ono	ding P. h. After t funera		27. Manner of Ďeath  1 ★Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day		Wo	ıryat ırk? ]Yes 2∐No	28d. Describ	e how inju	iry occurred		
Division or	if or Attending after death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could not be determined		y - At home, farm, s (Specify)	treet, factory, office			(Street a own, Stat		ural Route Number,	
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C		nysician: To the best of miner: On the basis of and manner state	examination and/or i							
)	To th withir To th	Me	29b. Signature and the or certifier	Junh.		29c. Licen	se number		29d. Da	ate signed (Mont	h, Day, Year) 2009	
			30. Name and address of person who	(KAUNI	ath (Item 23a) (Type	bella. I	Ela	mot 10	b ()	Monde	16 AD	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar		1						
	Regist	ar	JUL 142	009 Seneu	n B. A	garris						

09-05413 Cha

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

rles Hicks	1-1	State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Certificate of Death  Reg. No.  2009 2234
Physician/	<b>Re</b> 1.	Decement's Name (First, Middle-Last)  2. Date of Death Month Day Year 1716 hrs  July 10, 2009
רלי ' Examine		Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
		Bon Secours Hospital  Baltimore  Social Security Number 6, Sex 7, Age (In yrs. last birthday)  If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9, Birthplace (State or Foreign Country) 9, Country 1, Country
Funeral Director	5.	Social Security Number 6. Sex 7. Age (In yrs. last birthday) 4. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Age (In yrs. last birthday) 9
<b>&gt;</b>	_	sual Residence of Decedent  10d. Inside City Limits
d de de de de de de de de de de de de de		Ba. Himore
r death with the Maryland or items 23a or 28a-f shumust be notified at once	1	De. Street and Number  SER N. F. 1400 Avenue. 21217  USA
with the s 23a or e notifie	5   5   1	1 Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent Of Hispanic Origin? (Specify Yes or No- White etc.  White etc.
death v		Never Married 2 Married 1 Yes, Specify: Specify: Specify: Black
urs after tural", aminer	⋧┞	Widowed 4 Divorced If Yes, Give Year or Dates:  1 Yes 2 No specify:  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)
36 n 72 hoi nan "na lical Ex	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver Transport
AD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matter other than "natural", or items 13a or 28a-f she matter of the Medical Examiner must be notified at once	E	7- Eather's Name (First, Middle, Last)
2121 Ild be fil Mental I marked	o Be	Robert L. Hicks Or.  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
MD and 2 shot shifth and 1 m 27 is 1 aumatic	<u> </u>	oa Informant's Name/Relationship (Type, Print) Wite 1558 N. Futon Ave. Bultimore mD 21217  Non Method of Disposition (Name of cemeyery, Date 20c. Location - City or Town, State
S l ar		1 X Burial 2 Cremation 3 Removal from State 1 2 300 end on 7.16.09 Baltimore 700
Baltimore, permit. Pages I a Department of He Important: If ite injury or other tr	1	21. Signatur of Full and Service Service Service S
m உட்≞.≝ Physician		Approximate Interval Between Onset and
ledical aminer		failure. List Tily one cause on each line.  Death  Immediate Cause (Final disease a. Acute Coronary Artery Thrombosis
		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.
		if any, leading to immediate Due to (or as a consequence or).  cause. Enter Underlying Cause C.  c.
	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
e executed ician and irial - transit	dical	UNPENDED AMENDED 23d. Date of delivery
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be him 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physici the Funeral Director: After this certificate has been signed by the attending physici mpletely filled in by the funeral director, page 2 should be detached for use as the burn	sician/Me	IF FEMALE: 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  Month Day Year
ox 6 eath cert	sicia	1 Yes 2 No 9 Unknown 9 Unknown
P.O. B ss that the d gned by the	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
cords, P.O. I law requires that the has been signed by the standard of the sta	ted b	24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of
Record The law re	Completed	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
Vital Recolysician: The law	Be Cc	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Hospital: 1 Nursing Home 5 Residence 6 Other:
n of Vit ling Physic  After this	2	1 ✓ Yes 2 No Implated 2 ✓ 275 October 1 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
Sion ( Attending death. ctor: At	ation	1 V Natural 5 Pending Investigation 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City State)
Division of Vital Records, Hospital or Attending Physician: The law requir 24 hours after death. Funeral Director: After this certificate has been si stely filled in by the funeral director, page 2 should t	Certification:	3 Suicide 6 Could not be determined (Specify)
To the Hospital Within 24 hours To the Funeral completely filled	cal C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)
To the Hos within 24 h To the Fur completely	Medical	and manner stated.  29c. License number  29d. Date signed (Month, Day, Year)
		Slukell O.C.M.E. July 11, 2009
		Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
	tate	31. Date filed (Month, Day, Year)  32. Registrar's Signature
Regis		JUL 1 400009 Chroma Programme Original

DHMH 17 Rev 1/2001 OCME 2006

			1 - For State Registrar	Otate of Wil	ai yiaii		rtificate of		Wichtarry	Reg. No	700	9 2	22341
	Physici	an	1. Decedent's Name (First, Middle,						2. Date of De	eath Da	ay Ye		. Time of Death
1	/Medi		Bettie Ann Hi						July	12	$\frac{2}{20}$		1330 PM
	Examir	ner	4a. Facility Name (If not institution, s Seasons Hospice	·	Нос	nital	4b. City, Town, or	Listown	tn	40	County of E	eath imor	
	Funeral	_				PICAL last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Bi	rth			
	Director		213-32-0930	1□M 2X F		74 Yrs.	Months Days	Hours Min	8. Date of Bi (Month, D May 3	$1, {}^{\text{Year}}$	935	Mary	e (State or Foreign land
	pu v		Usual Residence of Decedent  10a. State 10b. County		100 Cit	y, Town or Lo	nation					104	Inside City Limits
	laryla sho	ō			100. 01								1 Yes 2 No
	28a-	rect	Maryland N/A			Balt	imore 10f. Zip Code			10a. C	itizen of What		21
	3a or	Funeral Director	2710 Huron Stre	et				230		J	USA	ĺ	
	death	ner	11. Marital Status	12. Was Decedent	Ever in U.	S. 13. \	Vas Decedent of H f Yes, specify Cuba	lispanic Origin? (	Specify Yes or No	D-	14. Race - A	American I	ndian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exercises out to be puilted at once.	by Fu	1 Never Married 2 Married	If Yes, Give	No		I□Yes 2ሺ No	Specify:	io i noun, oto.)		Specify: W		
215-0036	hours tural"	ed b	3 X Widowed 4 ☐ Divorced	Year or Dates:		16a Decer	dent's Usual Occup	ation		16b ł	Kind of Busine		rv
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213	d with	E O	Elementary/Secondary (0-12)	College (1-401 c	·+ <i>)</i>	Admin	istrativ	e Assist	ant		Cemet	ery	
pu	be file tal Hy d oth event	Be	17. Father's Name (First, Middle, La	•					me (First, Middle		,		
Maryland	ould a Men	၉	Ernest Joseph F			T			ne Mary				
Z Z	d2sh than 17isn traur		19a. Informant's Name/Relationship	, , ,			g Address (Street Rosalie			-	or Town, Sta yland		
	tem 2		Tarmy Nicholson, Daug 20a. Method of Disposition	,	20b. F		sition (Name of natory or other place		Date ,	_	ocation - City		
OE	Pages lent or nt: If i		1 ☐ Burial 2 🖾 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				ematory or other place		13/09	Bal	timore	. Mai	rvland
Baltimore,	permit. Departir Importa any inju		21. Signature of Funeral Service Lic										
<u>B</u>	8.8 <b>E 8</b>		Thomas	Yu -		25	Name and Addre emation 99 Freder	ick Road	L_Baltim	ore,	Maryl	and 2	21228
	Physician /Medical		23a. Part 1. Enter the disease, or or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	omplications that caused ly one cause on each line a	tast	atic	er the mode of dyir		ac or respiratory a	arrest,		Ap Inte On	proximate erval Between set and Death
	Examiner	Jer	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or as	a conseq	uence of):							
	icate be executed physician and the burial-transit	Examiner	that initiated events	с									
30,	oe execian a		resulting in death) Last	Due to (or as	a consequ	uence of):							
68760,	rtificate land physical ras the b	Medical		d									
O. Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1  ☐ Live birth 4  ☐ Pregnant a 9  ☐ Unknown	2 Feta	Ideath 3□	Ectopic pregnanc Other (specify)	у			23d. Date of Month	delivery Day	y Year
٠ <u>.</u>	s that ned b	by Ph	Part II. Other significant condition	s contributing to death b	ut not resi	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did	tobacco	use contribut	te to the ca	ause of death?
ırdı	w requires been sign should be	ed b							1/2	Yes 2	2 □ No 3 □	] Probably	y 4 ☐ Unknown
of Vital Records,	law re las be 2 sho	Completed			_				24a. Was		24b. Were	e autopsy	findings available
E H	ian; The rtificate h tor, page	Con							perfo 1 □ Yes	ormed? 2 ₩ N	deat	h? '	
Vit.	sician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:			. a D DOA Oth	or.	ath (Check only		41	SI	ARMIT HASO
oţ	Physer this	۲: To	1 ☐ Yes 2 ☐ No  27. Manner of Death	28a. Date of Inju	ry	ER/Outpatien 28b. Time of	I 3 LI DOA	4 LI Nursing	Home 5 ☐ Res 28d. Describe		6 Other (	Specify)	11-0103 1101
ion	Attending r death. ector: After by the funer	ation	1 1 Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Da	y, Year)	Injury	28c. Injur Worl M 1 🗆	ć? Yes 2 □No		,	,		
Division	al or Attences after death	Certification:	3 ☐ Suicide 6 ☐ Could not determine		ury - At ho	ome, farm, stre	eet, factory, office		28f. Location ( City or To			r Rural Ro	oute Number,
	To the Hospital or a within 24 hours after To the Funeral Direction Completely filled in b	Medical (		Physician: To the best aminer: On the basis o and manner sta	f examina								
	To th withii To th comp	M	29b. Signature and title of certifier	0 .			29c. Licens				ate signed (M		
			► Nerheallu	e Senter	1		1+4	15931		JU	ly 13	MZ	209
	10 /		30. Name and address of person when the second seco	o completed cause of d	eath (Item	23a) (Type, 1	Print) 5 Smith	Avonu	o Suite	200	Balt	More	3 MD
			-1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	20.5	1 01								

DHMH 17 Rev 1/2001

Registrar

		Please Type or Print in Bla  State of Maryland  1 - State Registrar	/ Depa		lealth and N	lental Hyg	_	ng 22313		
Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Janice Wagner Harwood				2. Date of Deat July	12 <sup>pay</sup> 200	3. Time of Death 10:15A M		
Examin		4a. Facility Name (If not institution, give street and number) Holly Hill Nursing & Rehabilitation Cente	er	4b. City, Town, or Towson	Location of Death		4c. County o	of Death imore		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. las $296-28-0865$ 1 $\square$ M 2 $\square$ F 7.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day June 13	, 1935	9. Birthplace (State or Foreign Country) Onlo		
filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f show ent, the Medienl Evaniner must be notified at	Funeral Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, Temperature 10c. City, Temperature 10c. Street and Number	Town or Loo	cation		1	0g. Citizen of WI	10d. Inside City Limits 1 ☐ Yes 2 ☑ No		
th with 23a or	ral Di	620 Stevenson Lane		21.2	.86		USA			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Evantral must be notified at once.	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, 2 Mo If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba I □Yes 2ሺNo	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		- American Indian, k, White, etc. White		
within 72 ho giene. r than "natur in Medien	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	16a. Deced (Give life. L	dent's Usual Occupa kind of work done d DO NOT use retired cher	ation during most of work )	ing	16b. Kind of Bus ${\sf Coll}$	•		
2 should be filed and Mental Hyg is marked othe raumatic event,	To Be C	17. Father's Name (First, Middle, Last) Clarence LeRoy Wagner				lys Myers	3			
and 2 sh ealth and n 27 is n		19a. Informant's Name/Relationship (Type. Print) Herbert Harwood, Husband		ng Address <i>(Street &amp;</i> S <b>teve</b> nson						
Pages 1 ament of He ant: If Item		4 Donation 5 Other (Specify)	o Cre	sition (Name of natory or other place ematory I		Date 13/09		ore, Maryland		
permit. Departr Importa any injt		21. Signature of Funeral Service Licensee Thomas Gregor		emation 9 Freder	Society (	of Maryla Baltimo	and, Inc	/land 21228		
Physician /Medical Examiner pnulal-transit	Examiner	23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one use on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate causes. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence or injury that initiated events resulting in death) Last  Due to (or as a consequence or injury that initiated events resulting in death) Last	Do not enter once of):		g, such as cardiac			Approximate Interval Between Onset and Death		
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i: The law re icate has be ; page 2 sho	Completed	Dep	one	nio		24a. Was a autops perforr 1 🗆 Yes 2	ned? pr	Vere autopsy findings available rior to completion of cause of eath?  ☐ Yes 2 ☐ No		
anding Phystcian: The ath.  After this certificate he funeral director, page	ation: To Be	1 Natural 5 □ Pending (Month, Day, Year) 2 □ Accident investigation	R/Outpatien 8b. Time of Injury	28c. Injury Work	4 Nursing H	th (Check only on ome 5  Reside 28d. Describe ho	ence 6 Othe			
is all led	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At hombuilding, etc. (Specify)				City or Towr	n, State)	er or Rural Route Number,		
the Hospital hin 24 hours a the Funeral I npletely filled	Medical	29a. Certifier (Check only one)  1 ▼ Certifying Physician: To the best of my knowle and manner stated.	edge, death n and/or in	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	, and due to the c red at the time, d	ause(s) and mar ate and place, a	nner as stated. nd due to the cause(s)		
To t With com	Σ	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  7 13 109								
101			3a) (Type, I	Print) TS W	ENUE	•	212	15		
Stat Registra		31. Date filed (Month, Day, Year)  32. Figistra's Signatur  32. Figistra's Signatur	1. 4	all						

amend #18 &26 State of the ARMEN G888 and Arms of the alth and Mental Hygienes For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** A M Katherine I. 2009 12:45 Hunt July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Candle Light Cove Assisted Living Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs, last birthday) Funeral 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1 □ M 2 F Maryland Director 578-22-8951 SEP 13, 1924 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location MD Talbot 1 ☐ Yes 2 X No Director Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 106 West Earl Avenue 21601 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 No Specify: Specify: White Completed by 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 21 Elementary/Secondary (0-12) 10 College (1-4or 5+) Homemaker Own Home 2 and 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gordon Fling ျှ Gray Zillah Sline 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol McLain, daughter 6874 Thorneton Road Easton, Maryland 21601 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town. State Pages 1 50 Metro Crematory, Inc. 07/13/09 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility Cremation Society of MD, Inc. 21. Signature of Funeral Service Licensee Thomas Gregor 299 Frederick Road Baltimore, MD 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): METASTATIC CAPENOMA OF BREASI Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an page 2 autopsy perforn this certificate 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Other (Specify) Assisted 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To funeral 28b. Time of 27. Man fer of Death 28a. Date of Injury (Month, Day, Year) After 1 Natural 5 Pending investigation ours after death.

leral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral L 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29b. Signature nd title of certifier D0057908 Miluny 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 800 S. TALANT ST BT MICHAELS PATTENSON 32. Registrar's Signature 31. Date filed (Month, State Sever S. Sark Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 0405 M / lana July 10 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days DEC. 10 1998 MARYLAND 219-53-3142 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 X Yes 2 No Director MARYLAND N/ABALTIMORE 10e. Street and Number 10g. Citizen of What Country? Funeral 1508 W. FAIRMOUNT AVENUE U.S.A. 21223 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No 1 X Never Married 2 Married 1 Yes 2 No Specify. If Yes, Give Year or Dates: Specify:\_BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5th grade STUDENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be NINO HINES SR. ၉ LATISA SMITH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Latisa Hines/Mother 1508 W. Fairmount Ave., Baltimore, Maryland 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State \*\*Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 07-16-09 WOODLAWN, MARYLAND WOODLAWN CEMETERY WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. elelilei 1206 W NORTH AVENUE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of a chine. Approximate Interval Between Onset and Death Immediate Cause (Final

**Physician** /Medical **Examiner** 

physician and is the burial-transit

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Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

**Funeral** 

**Director** 

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Examiner

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"natural",

of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me

Department of Health ar Important: If item 27 is any injury or other trau

with the Maryland or 28a-f show notified at

Pages 1 and 2 should be filed within 72 hours after death

Baltimore, Maryland 21215-0036

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State Registrar

29b. Signature

and title of certifie

30. Name and address of person wh

31. Date filed (Month, Day, Year)

	disease or condition resulting in death)	a. Due o (or al a conse		I We C.	1	
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conse	que ce off.	lastic Lea	Kemia	
by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	23c. If yes, outcome of pregr 1	tal death 3   Ectopic	c pregnancy spec <i>ify</i> )		23d. Date of delivery Month Day Year
ed by Pr	Part II. Other significant conditions of	ontributing to death but not re	esulting in the underlyin	ng cause given in Part I.		use contribute to the cause of death?
Completed					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No
Be	25. Was case referred to medical examiner?				eath (Check only one)	
2	1 Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatient 3 ☐	DOA Other: 4 Nursing	Home 5 Residence	6 C Other (Specify)
	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ury occurred
Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - At h building, etc. (Special		ory, office	28f. Location (Street a City or Town, State	and Number or Rural Route Number,
dical (		ysician: To the best of my kniner: On the basis of examin and manner stated.				s) and manner as stated. nd place, and due to the cause(s)

29c. License number

DGG 5 6 517

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

DHMH 17 Rev 1/2001

nours after death.

neral Director: Af

filled in by the fu

e Funeral I within 24 hour to the Funer completely file the

p completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death July 11, **Physician** 2009 John Lloyd Heim 8:58 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1834 Steven Drive Edgewood Harford 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year 09/25/1938 9. Birthplace (State or Foreign 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 ★M 2 □ F 219 38 1563 70 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10h. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Inc Medical Examination and the medities at 1 ☐Yes 2 ☐ No Director Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1834 Steven Drive 21040 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Xyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify. Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Fireman Baltimore County 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John N. Heim Kathyrn Ann Hill ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joann Heim (wife) 1834 Steven Drive Edgewood Maryland 21040 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Openation 5 Other (Specify) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Holly Hill Mem Gardens 7/15/2009 Middle River, Maryland 22. Name and Address of Facility Bruz Zinski Funeral Home PA ure of Funeral Service 1407 Old Eastern Avenue Essex Maryland 21221 23a. Part 1. Enter the disease, or shock or heart failure. List complications that caused the death. only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a conse Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence) Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaccourse contribute to the cause of death? ð 1 Dres 2 No 3 Probably 4 Unknown Completed page 2 should peen 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy performed death? certificate 1 ☐Yes 2 ☐ No 1 ☐Yes 2√ No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2XINo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending 1 24 hours after death.

He Funeral Director: After the further of the further 1 □Yes 2 □No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Box 68760, Records, P.O. Division of Vital

Baltimore, Maryland 21215-0036

mpletely To the I within 2

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who moleted cause of di

State Registrar

Medical

31. Date filed (Month, Day, Year 1 4 2009

29a, Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Year **Physician** Month 6:42 AM Helen 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore HOSPICE Baltimore, Glunst If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
 Country) **Funeral** Months North 1 □ M 2 🕶 🗲 -34-1485 Carolina Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examinar must be notified at 1 Tes 2 □ No **Funeral Director** saltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. tre 21212 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Blac If Yes, Give Year or Dates: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) lurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any Injury or other trau once. Baltimore, daughter enton esree. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Lorraine tark Cemetur 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Howell MD 21207 4600 Balto iberty Heights 1 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** N 00 small cell /Medical Due to (or as a consequence of): Examiner dertensur Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Diabetes Mellitus Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Vear 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 □Yes 2 ◯ No 24b. Were autopsy findings available prior to completion of cause of death? Obstructive stee certificate 2 □No Division of Vital 1 Tyes the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at After 5 Pending investigation 1 ☐Yes 2 ☐No within 24 hours after death.

To the Funeral Director: /
completely filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

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31. Date filed (Month, Day, Year)

West Towsentown Blud

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar's Signatur

	1	For State Registrar			rtificate of	Health and I Death	F	Reg. No.	2009	2234
hysician	ı	1. Decedent's Name <i>(First, Middl</i> e, <i>Las</i> <b>JACOB</b>	<i>n</i> A		HAMAN		2. Date of Dea Month JULY	Day	2009	3. Time of Death
/Medical Examiner		la. Facility Name (If not institution, give			1	r Location of Death			County of Death	10.20 A
-xammer	ı	COURTLAND GARDI	ENS			TIMORE			BALTIMO	RE
uneral rector		214-14 <b>-</b> 2460	7. Age (li	n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day 06/23/		9. Birthp Cour	place (State or Fore htry) MD
Mo to	- }-	Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	cation				1	0d. Inside City Limi
a-f sh		MD BALTIMO	ORE	BA	LTIMORE					1 □Yes 2 📉 N
or 28a-f st be notified Director		0e. Street and Number	'		10f. Zip Code			10g. Citi	zen of What Cour	ntry?
s 23a		7920 SCOTTS LEVE			212				USA	
turally or items 23a or 28a-f show all Exmutitive must be mutified at ed by Funeral Director		11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Ever Armed Forces? 1	WW I I	was Decedent of heart of the free free free free free free free fr	dispanic Origin? (S an, Mexican, Puerti Specify:	pecity Yes or No- o Rican, etc.)		14. Race - Americ Black, White, Specify: WHI	etc.
"natur fical		15. Decedent's Edu (Specify only highest grad	ucation de completed)	16a. Dece	dent's Usual Occup	oation during most of word d)	kina	16b. Kir	nd of Business/Inc	dustry
_ 91		Elementary/Secondary (0-12)	College (1-4or 5+)	`life.	OO NOT use retire				TAVT	
other than vent, tre M Se Comp		17. Father's Name (First, Middle, Last)			OWNER/ UP	18. Mother's Nam	ne (First, Middle,		TAXI Surname)	
arked ott atic even To Be	1	MORRIS	LOUIS	HAMAN	1	JENN	ITF		SCHOO	KET
s mar		19a. Informant's Name/Relationship (7				and Number of Bu	_	er, City o		
If Item 27 is marked other or other traumatic event, III			AUGHTER	3021	<b>FALLSTAF</b>	F ROAD, E	BALTIMORI	E,_M	D 21209	
or oth	1	20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ I	Removal from State	30b. Place of Dispo BETHT <sup>et</sup> HAME	sition (Name of	ce)	Date	20c. Lo	cation - City or To	wn, State
rtant:	L	4 ☐ Donation 5 ☐ Other (Specify	) [1	HAGODOL		:07/12	2/2009	R0	SEDALE,	MD
Important: If Item 27 is any injury or other tra	-	21. Signature of Funeral Service bicens	W.	8		TERSTOWN	RD., PII	KESV	& BROS., ILLE, MD	21208
sician edical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	aV	4s cular =		ng, such as cardiac	or respiratory an	rest,		Approximate Interval Between Onset and Death
miner		Sequentially list conditions	Due to (or as a co	nsequence of):						
nine		Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or Injury	Due to (or as a co	nsequence of):						
attending physician and for use as the burial-transit size.		that initiated events resulting in death) Last	Due to (or as a co	nsequence of):						
as the bur	-		d					1		
d by the attending etached for use as Physician/Me		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	Ectopic pregnand Other (specify) _	су		2	23d. Date of delive Month	ery Day Year
be d		Part II. Other significant conditions co	ntributing to death but no	ot resulting in the u	nderlying cause giv	en in Part I.				ne cause of death?
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ficate has been s r, page 2 should Completed		25. Was case referred to medical					24a. Was a autop perfor 1 □ Yes	sy med? 2 No	24b. Were auto prior to co death? 1 □Yes	psy findings availa mpletion of cause of 2 No
irector	т	examiner?	Hospital:	2 ER/Outpatier	oth	AOF:	th (Check only of		. Flort (0 :	
er this	2	27. Manner of Death	28a. Date of Injury	28b. Time o			ome 5 ☐ Hesio 28d. Describe h		G ☐ Other (Special occurred)	<u>y)                                    </u>
or: Aff the fun catio		1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day, Ye	ar) Injury		Yes 2 □ No				
al Director: After this led in by the funeral dir		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, str Specify)	eet, factory, office		28f. Location (S City or Tow	Street and In, State,	d Number or Rura )	al Route Number,
To the Funeral Director: After this certificate in completely filled in by the funeral director, page Medical Certification: To Be Com		29a. Certifier (Check only one) 2 Medical Exam	rsician: To the best of m iner: On the basis of exa and manner stated	amination and/or in	h occurred at the ti vestigation, in my	ime, date and place opinion, death occu	rred at the time,	cause(s) date and	and manner as s place, and due to	stated. the cause(s)
comp		29b. Signature and title of certifier			29c. Licens	se number		29d. Dat	e signed (Month,	Day, Year)
		Maymora Mille	~ Mo		D47	68.3		7/8	109	
, I	-	Name and address of person who c		(Item 23a) (Type.	Print)					
5	3	Raymond Millir 25		( ====) () ()	,					

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 53 Rita Pauline Kozub 2809 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Delther Health and Behablitation If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) Date of Birth (Month, Day, **Funeral** Months Days 1 M 2 3 F Director 88 15, 1921 577-24-6524 Feb. Iowa Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exaction or must be multiped at once. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 XNo Directo Maryland Harford <u>Abingdon</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21009 USA 3023 Laurel Bush Road Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No <u>^</u> If Yes, Give Year or Dates: Specify: Specify: 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Personnel Management Specialist U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cecil Mae Criswell ပ္ Charles Paul Martin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Henninger / Attorney 5 S. Hickory Ave., Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Hilltop Service Corp. 7-13-09 Towson, Maryland 22. Name and Address of Facility

McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee lig (usa 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) NY Carres /Medical Due to (or as consequency of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transi attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown been signed by should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 9 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed this certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No of Vital Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Division 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Momicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier o M 7/10/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAYS ST #102, BELAIR MD 24016 KHOSLA 206

Registrar

DHMH 17 Rev 1/2001

State

32. Registrar Signat

State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Jochell Physician Sa 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Calvert 4618 Green Ridge Court Huntingtown Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Min. 1 □ M 2 🛛 F Months Days Hours 551-17-7631 45 8/18/1963 California Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 X No Director MDCalvert Huntingtown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20639 4618 Green Ridge Court U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 1 Married White 1 ☐Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed and 2 should be filed within 72 ho teath and Mental Hygiene.
m 27 is marked other than "natur her traumatic event, Inc.] rediction 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Home Administrator Health Care 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Faye Womack Gerald Openshaw ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Perry Joseph Kochell/Husband 4618 Green Ridge Court, Huntingtown, MD 20639 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/14/2009 | Hanover, Maryland Anatomy Gifts Registry 4

☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Lice 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a con: **Examiner** Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner requires that the death certificate be executed burial-tran Due to (or as a conseque physician s the burial Physician/Medical attending p for use as 1 Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 2 █No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy page 2 No 1 ☐ Yes 2 ☐ No Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Mo Certification: To ō 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending Division 1 KNatural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director: # 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 29a. Certifier 1XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10026010 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person egistrar's Signatur 31. Date filed (Month, Day, Year) State your Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22351 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day **Physician** Lois M. King 4.39AM 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Ellicott City Health & Rehab Ellicott Citv Howard Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 □ M 🗶 □ F Director 219-10-2402 100 Jun. 28, 1909 Maryland Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland i and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a, State 10c. City, Town or Location in than "natural", or items 23a or 28a-f show 1 ∐Yes 2X No Director MD Baltimore Lansdowne 10e. Street and Number 10g. Citizen of What Country? 305 Clvde Avenue 21227 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Music Teacher <u>Self Employed</u> permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth-any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William J. King Emma E. Silcott 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) William Robert Wolfe 2626 Jonathan Road Ellicott City MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition NX Burial 2 ☐ Cremation 3 ☐ Removal from State oudon Park Cemetery 7-10-2009 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. Signature of Funeral Service 1328 Sulphur Spring Rd., Arbutus, MD 21227 Approximate Interval Between Onset and Death Tart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Alhero Sclevo tic Carcles Vancular **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Dav 5 ☐ Other (specify) □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending I hin 24 hours after death. the Funeral Director: After 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 🗆 No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifig 30641 ann

State Registrar

DHMH 17 Rev 1/2001

BackRiverneck load

Name and address of person who completed cause of death (Item 23a) (Type, Print)

201-109

Jahapalmi

31. Date filed (Month, Day, Year)

# ■ Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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Physicia /Medic		John Robert Kramer, Sr.							July 7, 2009 Year 6			
Examin		4a. Facility Name (If not institution, give str	ŕ				r Location of Death	n		County of Death		
/ 		5610 Queen Anne S 5. Social Security Number 6. Sex								altimore 9 Birth		
Funeral Director			4 2 T E	81	Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da Sept. 3.			nplace (State or Foreign untry)	
P		Usual Residence of Decedent						Dept. J.	1341	Mary		
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he M	Director	Maryland Baltimore  10e. Street and Number		G <sup>-</sup>	wynn	0ak 10f. Zip Code			10° Citi	izen of What Cou		
with t	ä	5610 Queen Anne St	root				207			SA	muy:	
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filed within 72 hours after death with the Maryland Hygiene. Hygiene, wither than "natural", or items 23a or 28a-f show ant, the Madical Examinar mast be rediffed at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	WWII							nite 	
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ertifica ling ph	Physician/Medica	IF FEMALE:										
attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	<ol> <li>If yes, outcome</li> <li>Live birth</li> </ol>	2 Feta	I death	Ectopic pregnanc	су			23d. Date of deli Month	ivery Day Year	
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ding th. After	tion	1 Natural 5 Pending investigation	(Month, Da	ay, Year)	Injury	Wor	rk? ]Yes 2 □ No	Zou. Describe i	iow injui	y occurred		
Atter r dear ector: by the	ifica	3 Suicide 6 Could not be determined	28e. Place of In	jury - At ho	pme, farm, s	street, factory, office		28f. Location (3	Street an	nd Number or Ru	ıral Route Number,	
taf or	Certification:	4   Homicide	building, e	ic. (Specif	<i>y)</i>			City or To	vii, State	*)		
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the total completely filled in the funeral director.	Medical	29a. Certifier (Check only one)  Certifying Physi 2 Medical Examine		of examina								
To the within comp	ğ	29b. Signature and title of certifier	k, m	7		29c. Licens	se number			te signed (Montl	n, Day, Year)	
ipt		30. Name and address of person who com	pleted cause of	death (Iten	n 23a) (Typ	e, Print)	Kal+	t mi	70	7.17	199	
Sta	e	31. Date filed (Month, Day, Year)	32. P gist	rar's Signa	ture	y we	12411	0 1117		VILL	/	
Registra	ar	JUL 1 4 200	9 Sener	u.	A. 4	bare						
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician /Medical Andrea -00 4c. County of Deat 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** 8. Date of Birth (Month, Day Jan 19 9. Birthplace (State or Foreign Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 5. Social Security Number **Funeral** Hours 1 M 2 W 215-23-400 yaryland **Director** Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f show must be notified at Baltimore 1 Yes 2 □ No Director Maryland 10e. Street and Number 10g. Citizen of What C 10f. Zip-Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important. If item 27 is marked other than "p.c." any Injury or other traumation. ö Melvin items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever 1 U.S. Armed Forces? 1 ☐ Yes 2 Û No If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Studen 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Huntles မ 19a. Informant's Name/Relatio s' ip (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hen Burnie Huntley Dukes-mother Caro 20b. Place of Disposition (Name of cemetery, cremetory or other p 20a. Method of Disposition Date 1 Dourial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 2515 disease or condition resulting in death) /Medical Due to (or a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 - Fetal death 3 Ectopic pregnancy signed by the atter d be detached for in the past 12 months? Month Day Year 4 Pregnant at time of death
9 Unknown 5 Other (specify) 2 No 9 X Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 X No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performe 2 No 1 Yes after death.

Director: After this certificate director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \( \subseteq \text{Nursing Home} \) 5 \( \subseteq \text{Residence} \) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) မ filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation or Attending 1 Natural Injury 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide 24 hours Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (check only Medical one) within 2 To the

State Registrar

Jahrie 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

18929

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

Amend 4b & 28f, per MD g893 7/14/09 TT
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month AM **Physician** 2:00 LACOMB JULY AUGUSTUS J 2009 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE; KERNAN HOSPITAL Birthplece (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months 1 M 2 □ F Nov. 18, 1941 Director 105-32-4742 New York Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location r 28a-f show 1 Yes 2 No Maryland Harford Joppatowne 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or USA 21085 503 Haverhill Road Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced White al Hygiene. I other than "natura vent, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Military U.S. Government ith and Mental Hygis 27 Is marked other r treumatic event, II 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Katherine Elizabeth Sharland Augustus John LaComb Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health i Jill Arkins / Daughter 321 Jones Road, Fawn Grove, Pennsylvania, 17321 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pages 1 Department of H Important: If Ite any injury or ot once. Hilltop Service Corp. 7/13/2009 Towson, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Cicenses 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or cooplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. COMPLICATIONS Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MULTIPLE INJURIES WITH **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of) Iclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) Physi 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. ð MELLITUS DIABETES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed HYPERTENSION 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner?

124 Yes 2 \( \text{No} \) No 26. Place of Death (Check only one) Hospital: 1 

Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Certification: After 5 Pending investigation 1 Natural JUNE 7- 2009 4:30 PM MOTOR VEHICLE ACCIDENT 1 ☐ Yes 2 XNo within 24 hours after death. To the Funeral Director: A 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) RT. 23 AND WHITE 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide MALURD WAY

WALURD WAY

WALURD WAY

WALURD WAR Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause() and manifer as the cause(s) and manifer stated. 21740 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number elsem Makonnen, MD D0058009 JULY

Registrar

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

P.O.

Division of Vital Records,

DHMH 17 Rev 1/2001

BALTIMORE, MD 21207

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cener

ZELALEM MAKONNEN 2200 KERNAN DRIVE

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 3. Time of Death

444

P 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** am VINO war 2009 /Medical Facility Name (If not institution, give 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Medical a Himos 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 82 Yrs. 6. Sex Funeral Min 1**√** M 2□ F Months Days Hours 7, 1926 Director MAryland 220**-1**8-6831 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a. State 27 Is marked other than "natural", or items 23a or 28a-f shor traumatic event, It is Medical Examinar must be notified at 1 ☐Yes 2 ☑ No Director MD Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21207 United States 1112 Landington Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1XIYes 2 \( \text{No} \) No \( \text{1943} - \) Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify. þ Specify: White 3 Widowed 4 Divorced 1944 Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Route Salesman Grocery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumattc ev Joseph Lawrence Lamp Cora Irene Welling 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty M. Lamp 1112 Landington Avenue Baltimore, MD 21207 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-14-2009 Atlantic Crematory Glen Burnie, MD 22. Name and Address of Facility Ambrose Funeral Home, INC. 21. Signature of Funeral Service Licensee Tepe 1328 Sulphur Spring Road Arbutus , MD 21227 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical ue to (or as a con a quence of): reumonia. Examiner Se gentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 DNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 □Yes 2 PNo 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No

Box 68760. Ö <u>a</u>. Division of Vital Records,

The law requires that the death certificate be executed attending physician and for use as the burial-tran signed by the a peen has page 2 certificate this certific al director, After this funeral c Hospital or Attending after death.

Director: Afd in by the fur filled in by within 24 hours a

the as

28a-f show

filed within 72 hours after death with

d 2 should be filed within the and Mental Hygiene.

Baltimore, Maryland 21215-0036

Certification: To 2 Accident 3 ☐ Suicide 4 Homicide 29a. Certifier Medical (Check only one) 29b. Signature and title of dertifier,

State Registrar 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

who completed cause of death (Item 23a) (Type, Print)

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

	_1	For State of Maryland / Department State of Maryland / Ce	artment of Health and l rtificate of Death		ene J. NoO O O O	2225			
Physician /Medical	) 	1. Decedent's Name (First, Middle, Last)  At that e  At Facility Name (If not institution, give street and number)	Lipkin  4b. City, Town, or Location of Deat	2. Date of Death Month JULY	Day Year 9 2009 4c. County of Death	3. Time of Death 5:45 PM			
Examiner Funeral Director	i e	SINAI HOSPITAL OF BALTIMORE  5. Social Security Number  090-12-2695  6. Sex 1X M 2 F  84  Yrs.	BALTIMORE  If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	CITY	N/A 9. Birthp	olace (State or Foreign htry) NY			
vith the Maryland or or 28a-f show be notified at Director	r	Usual Residence of Decedent	ocation		10d. Inside 11/201				
urs after death v alf, or items 23a xaminer must	Dy ruileiai	1 Never Married 2 Married 1 W Vos 2 No	21209 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 ᠯ No Specify:	Specify Yes or No- to Rican, etc.)	USA  14. Race - Americ Black, White, Specify:				
be filed within 72 hou tall Hygiene. d other than "natura event, the Medical E	e combiered	(Specify only highest grade completed) (Give life.	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)  CHANICAL ENGINEER  18. Mother's Nar	rking 16	ELIPKIN TOO	·			
Theath and Manual be flie theath and Mental Hy tem 27 is marked oth other traumatic event	2	STANLEE LIPKIN / DAUGHTER 221	SOPH ng Address (Street and Number or Ri 5 SULGRAVE AVENUE	ural Route Number,	)RE, MD 21	Code) 209			
permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		4 Donation 5 Other (Specify) WELLWOOD	matory or other place)	0/2009	PINELAWN,	NY			
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.   PLEURAL EF  Due to (or as a consequence of):	ter the mode of dying, such as cardial	c or respiratory arres	NT MALICHA	Approximate Interval Between Onset and Death AT 7 DA			
tificate be executed g physician and as the burial-transit ledical Examiner	IICAI EVAIIIIICI	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  L YMPHOMA  Due to (or as a consequence of).  C.  Due to (or as a consequence of):				17 YEAR			
hat the death certific d by the attending p letached for use as	ly sicial trings		□Ectopic pregnancy □ Other (specify)		23d. Date of delive	ery Day Year			
w requires that the de been signed by the a should be detached feleted by Physic	<u>`</u>	Part II. Other significant conditions contributing to death but not resulting in the u  CORONARY ARTERY DISEAS		23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknow					
Iclan: The law requirem: The law requirem: Pertificate has been sector, page 2 should		25. Was case referred to medical examiner?	26. Place of De	24a. Was an autopsy perform 1 Yes 2 1 ath (Check only one	prior to co death? YNo 1 □ Yes	ppsy findings availab mpletion of cause of 2 No			
Attending Phys r death. ector: After this out the funeral direction: To	2	Hospital: 1 Impatient 2 ER/Outpatie   Review of Death   1 Matural   1 Matural   2 Manner of Death   2 Matural   5 Matural   5 Mending investigation   2 Medical	of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how	eet and Number or Run				
To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Certil		29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
		29b. Signature and title of certifier  Day Paul Agrawal, MD  30. Name and address of person who completed cause of death (Item 23a) (Type,  JAY PAUL AGRAWAL, MD	ı	d. Date signed (Month,	_				
Ve		SU. Name and address of person who completed cause of death (Item 23a) (Type, TAY PAUL AGRAWAL, MD	SINAI HO	SPITAL	OF BAL	TIMOR			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) JUL Y **Physician** 2009 6:42A LINDA SUSAN LEBOWITZ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANNE ARUNDEL 1213 BIRCHLEAF COURT CROFTON If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 06/06/1962 5. Social Security Number 7. Age (In yrs. last birthday) 47 Yrs. **Funeral** Min Days 1 □ M 2 💢 F PA 169-42-0119 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Evernher must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 ☐ Yes 2 No Director CROFTON MD ANNE ARUNDEL 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21114 USA 1213 BIRCHLEAF COURT Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 □Yes 2 □XNo Specify: WHITE Specify: Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) LAW ATTORNEY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EDWIN LEBOWITZ **DONNA** SHRADER ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) DONNA LEBOWITZ/MOTHER 1713 POINT NO POINT DRIVE, ANNAPOLIS, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BETH EL MEM.PARK 07/12/2009 RANDALLSTOWN, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21 Signature Funeral Service 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Immediate Cause (Final metas Physician tati disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transi Due to (or as a consequence of): physicians the burial Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 3 🗆 Ectopic pregnancy Day Month Year 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Physician: The law requires that the death certificate be executed Ö ۵. Division of Vital Records, Hospital or Attending

Baltimore, Maryland 21215-0036

State Registrar

Medical

29a. Certifier

one)

29b. Signature and title of certifier

R0808

Misiewic

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 7-11-09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltmar

Day, Ye. 31. Date filed (Month

32. Registrar's Signat

# Baltimore, Maryland 21215-0036

JIVISION OF VILAI RECOIDS, I	s, P.O. Box 68/60;
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. ? 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** (200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN Birthplace (State or Foreign Country)

WV 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 1 / 11 / 1908 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 X F Months Days Hours 216-01-7756 100 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 □Yes 2 No **Funeral Director** CABIN JOHN MD MONTGOMERY 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23a or? 6513 PERSIMMON TREE 20818 USA ROAD 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 1 ☐ Never Married 2 ☐ Married WHITE 1 □ Yes 2 No Specify: à If Yes, Give Year or Dates 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **LAZARUS ALEXANDER** CELIA KLEIN ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6513 PERSIMMON TREE RD., CABIN JOHN, MD 20818 ALAN LEVIN / SON 20b. Place of Disposition (Name of ANSTHER) ENTUNATH or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) AITZ CHAIM CONGREGATION 7/12/2009 BALTIMORE. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** veb, disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): for use as the burial-transi signed by the attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) be detached 1 □Yes 2 □No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 No page 2 should After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 2 □No 1 ☐ Yes ∣∐Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Secison's Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide 29a, Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

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			1 - State Registrar		Cei	rtificate of	Death		Reg. No. UL		
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Duwthy	maha	h			2. Date of Dea Month	Day	Year 22 P M	
and.	Examin		4a. Facility Name (If not institution, give st					4c. County			
			FRANKLIN SQU				Seclal			9. Birthplace (State or Foreign	
ı	Funeral Director		5. Social Security Number 215-16-5466  Usual Residence of Decedent	M 24□ F 88	s. last birthday) Yrs.	Months Days		January	th y, Year) 7 23,1921	1 Maryland	
	land ow		10a. State 10b. County		10d. Inside City Limits						
	Mary a-fsh	ţ	Maryland Baltimore Nottingham							1 ☐ Yes ŽÃ No	
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	Vhat Country?	
	ath w		9402 Belair Ro			21236		"		States	
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: If tier A7 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Evanime must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 _Yes 27 No If Yes, Give Year or Dates:		S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1  Yes 2  No Specify:  Specify: White					
21215-0036	2 hou atura	ed	15. Decedent's Educa	ation	16a. Dece	dent's Usual Occi	pation	tilaa	16b. Kind of Bu	siness/Industry	
215	hin 7: e. an "n Medi	Completed by	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	life.	(Give kind of work done during most of life. DO NOT use retired)  Homemaker		king	1.1		
2	ed wil	ပ္ပ	12		Homer			/Final Middle	Own Home		
gue	be fill htal H ed off	Be	17. Father's Name (First, Middle, Last)	Emons			i	<sub>ne (First, Miladie,</sub> known	, Maiden Surnam	ni Surname)	
Maryland	hould id Me mark matic	ျ	Unknown  19a. Informant's Name/Relationship (Typ	Franz	19h Mailir	na Address (Stree	et and Number or Ru		er. Citv or Town.	State. Zip Code)	
	nd 2 salth ar		Patricia A. Galiano			Penn Ave			Marylan		
Baltimore,	is 1 ar		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of matory or other pl	ace)	Date	20c. Location -	City or Town, State	
<u>=</u>	Page ment ant: If ant: If ury or		1 ☐ Burial 2 【XCremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State I	vview C	rematory	7/14			re, Maryland	
3alt	permit. Departi Importi any Inji		21. Signature of Funeral Service License	20						Home, Inc.	
ш	ZO = # 9	Ш	23a. Part 1. Enter the disease, or complic	lle						1and 21236  Approximate Interval Between	
,09	Physician /Medical Examiner pnulai-transit	al Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a)	den to	in som	of Dis	Ces.		Onset and Death	
	ficate phys s the	ğ	d.		***************************************						
Vision of Vital Records, P.O. Box 687 attending Physician: The law requires that the death certificate	the death certificate y the attending physiched for use as the body.	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 5 □ Other (specify)							te of delivery onth Day Year	
	ned by deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						obacco use contribute to the cause of death?		
g G	quires	g pg	I morent I chamile 10114 the							2 No 3 Probably 4 Unknown	
Division of Vital Records, I or Attending Physician: The law requires to	. The law requires that the disale has been signed by the page 2 should be detached	omplete								Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No	
<u>ta</u>	iclan: Th certificate ector, pag	Be C	25. Was case referred to medical examiner?					ath (Check only			
)† <b>C</b>	hysic this c		1 ☐ Yes 2 ☐ ¶0						ome 5 Residence 6 Other (Specify)		
ב	ding f	ioi	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury 28b. Time of 28c. Injury at Injury work?  MM 1 1 Yes 2				28d. Describe how injury occurred			
É	를 를 들	Certification: To	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined						per or Rural Route Number,		
	the Hospital hin 24 hours a the Funeral mpletely filled	Medical C		ician: To the best of my ki er: On the basis of examinand manner stated.							
	Vithir vithir Comp	M	29b. Signature and title of certifier		-m	_	nse number			d (Month, Day, Year)	
			• / 0	•	1/1/		31464		7()	3(09	
			30. Name and address of person who con	4 442 173	em 23a) (Type, W . E	Print) UTAW	ST Smile	300 1	BALTIN	no12F Mp 2120	
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Support of the property of the					1- State of Maryland / Department / Department / Departmen	artment of Health and Natificate of Death		jiene •g. No. 00	9	22361
TOTAL TOTAL STATE OF THE PARTY HAVE A STATE					Decedent's Name (First, Middle, Last)		2. Date of Dea	th	Vo	3. Time of Death
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Format Director    The Part					4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of	f Death	
Format Director    The Part		1			Harford Memorial Hospital	Havre de Grace		Н	arfo	rd
The control of the			Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth		9. Birthpl	lace (State or Foreign
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Continued   Cont	-	36	rs aft		1 Never married 2 Married 1 Tes 2 to No If Yes, Give A  3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify:	Wh	ite
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Due to (or as a consequence of):    Due to (or as a consequence of):				je.	sequentially list conditions if any, leading to immediate  Due to (or as a consequence of):					
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The state of the s	·		dea death	sicia	1 Yes 2 No 4 Pregnant at time of death 5			Mon	th	Day Year
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25. Was case referred to medical examiner?   1   Yes 2   No   1   Yes 2		Ö	lawr as be	pie				n 24b. W	ere autor	psy findings available
25. Was case referred to medical sexaminer?    State	. ~		The ete h page	PO			perform	med? de	eath?	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  WATAMATH (NOM (IN) 505 Upper Unapulse in 3rd Air no 21314  State 31. Date filed (Month, Day, Year) 3rd. Registrar's Signature	7	ita,	ian: ortific ctor,	0		26. Place of Dear				
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  WATAMATH (NOM (IN) 505 Upper Unapulse in 3rd Air no 21314  State 31. Date filed (Month, Day, Year) 3rd. Registrar's Signature			the hin 2 the l	Med	one) and manner stated.					
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WATANATH MONGINI 50's Upper Auspiele in Bul Air no 21314  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature					6 Series		2	1.12.	2007	
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July **Physician** 2009 Thomas 10:16 A M Eugene Myers, Sr. 10. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Howard County General Hospital Columbia Howard If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 XM 2□ F Months Days Hours Min Director 214-68-2138 53 SEP 4, 1955 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show items 23a or 28a-f sho 1 ☐ Yes 2 No Director MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11529 Little Patuxent Parkway 21044 USA Funeral death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status and 2 should be filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 ö other traumatic event, the Medical Evani 1 ☐ Yes 2 X No Specify: Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental h ဂ Eugene Myers Dorothy Wareheim 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other trains once. 1475 Falcon Nest Ct. Thomas E. Myers, Arnold, MD Jr., son 21012 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 【\*Cremation 3 ☐ Removal from State Metro Crematory, Inc. 07/13/09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation Society of MD, Inc. 21. Signature of Funeral Service Licensee George MacNabb Veos 299 Frederick Road Baltimore, MD 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Renal Failure attending physician and for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) P.0. signed by the a 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an 2 No 1 ☐ Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred al or Attending F safter death. I Director: After d in by the funera After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00066511 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5755 Cedar Lane Columbia, Maryland 21044 State

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Registrar

# permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Modical Extrainer must be notified at Baltimore, Maryland 21215-0036

Fune Direct

Physicia /Medic Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

August   A	nne Arundel  9. Birthplace (State or Foreign Country) Mary Land  10d. Inside City Limits 1 □ Yes 2 No hat Country?  A  - American Indian, t, White, etc.  White	
Charles Edward Miles  Charles Edward Miles  University Name (If not institution, give street and number) And Security Number Section of Death Security Number Section of Death Security Number Section of Death Security Number Section of Death Security Number Section of Death Security Number Section of Death Security Number Section of Death Security Number Section of Death Security Number Section of Death Security Number Section of Death Security Number Section of Death Section o	of Death  nne Arundel  9. Birthplace (State or Foreign Country)  Maryland  10d. Inside City Limits  1 □ Yes 2 No  hat Country?  A  American Indian,  White  Siness/Industry	
4a. Facility Name (If not institution, give street and number)  8443 Woodland Road  4b. City, Town, or Location of Death  Millersville  An  Social Security Number  216-68-6852  Usual Residence of Decedent  4c. County of  Millersville  An  An  An  An  An  An  An  An  An  A	nne Arundel  9. Birthplace (State or Foreign Country) Mary Land  10d. Inside City Limits 1 □ Yes 2 No hat Country?  A  - American Indian, t, White, etc.  White	
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Maryland   Anne Arundel   Millersville	nat Country?  A  - American Indian, , White, etc.  White siness/Industry	
10e. Street and Number   10f. Zip Code   10g. Citizen of Wr   10e. Street and Number   10e. Street and Number   10e. Street and Number   8443 Woodland Road   21108   US.   11. Marital Status   1   Never Married   2½ Married   1   1   1   1   1   1   1   1   1	A - American Indian, t, White, etc. White siness/Industry	
Section of Business   Section of Business	- American Indian, , White, etc. White siness/Industry	
11. Marital Status   12. Was Decedent Ever in U.S. Armed Forces?   13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)   14. Race Black, Specify:   1   Yes   2   No   1   Yes, specify Cuban, Mexican, Puerto Rican, etc.)   14. Race Black, Specify:   1   Yes   2   No   Specify:   Spe	, White, etc. White siness/Industry	
Truck in the late of Disposition    The late of Disposition   15. Decedent's Education (Specify only highest grade completed)   16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)   17. Father's Name (First, Middle, Lest)   18. Mother's Name (First, Middle, Maiden Surname, Delores Nelson   18. Mother's Name (First, Middle, Maiden Surname, Delores Nelson   19a. Informant's Name/Relationship (Type. Print)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S   8443 Woodland Road Millersville, Mary (20a. Method of Disposition   20b. Place of Disposition (Name of   Date   20c. Location - College (1.4 or 5+)   18b. Mailing Address (Street and Number or Rural Route Number, City or Town, S   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S   19b. Mailing Address (Street and Number or Rural Route N		
Truck Driver    September   February   Secondary (0-12)   College (1-4or 5+)   Truck Driver   Truck Driver	ng	
Tina Miles, Wife  20a. Method of Disposition  18. Mother's Name (First, Middle, Maiden Surname, Delores Nelson  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S  8443 Woodland Road Millersville, Mary  20a. Method of Disposition  20b. Place of Disposition (Name of Date 20c. Location - C		
Edward Miles  Pelores Nelson  19a. Informant's Name/Relationship (Type. Print)  Tina Miles, Wife  20a. Method of Disposition  Pelores Nelson  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S  8443 Woodland Road Millersville, Mary  20a. Method of Disposition  20b. Place of Disposition (Name of Date 20c. Location - C	r)	
19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S  8443 Woodland Road Millersville, Mary.  20a. Method of Disposition  20b. Place of Disposition (Name of Date 20c. Location - C		
11na Miles, wile 8443 Woodland Road MillersVIIIe, Mary  20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - C		
	City or Town, State	
1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)  And Donation 5 Other (Specify)  And Donation 5 Other (Specify)  And Donation 5 Other (Specify)  And Donation 5 Other (Specify)  Baltimore	e, Maryland	
21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland	c. y <b>i</b> and 21228	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	Approximate Interval Between Onset and Death	
aminer		
Sequelturally list controllors, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):		
di cal cal cal cal cal cal cal cal cal cal		
IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date	3d. Date of delivery Month Day Year	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.	ibute to the cause of death?  3 ☐ Probably 4 ☐ Unknown	
S B D D D D D D D D D D D D D D D D D D	Vere autopsy findings available rior to completion of cause of eath?  □Yes 2 □No	
1	1763 2 1110	
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other		
27. Manner of Death 1 Natural 2   Accident   Suicide   S		
3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number City or Town, State)		
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29b. Signature and title of certifier 29b. Date signed	and due to the cause(s)	
1 / Jemo (1/50) 1/3/557 7-10	(Month, Day, Year)	
30. Neigher and address of person who completed cause of death (Item 23a) (Type, Print)  1. USE I OLI DE CUCUS AND - 3 OS HOSP, Full DIVE, GAR BUTE, F.  State 31. Date filed (Month, Day, Year) - 32. Polither's Signature	0 1	
State Registrar  JUL 14 2009  Live J. Sagnature  J. Bev 1/2001	Mel. 2106/	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** DEBORAH MARSHALL TULY 2009 11 /Medical 4c, County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BAItO BALT MORE

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JOHNS HOPKINS BAYVIEW MEDICALCEROOS 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗗 F MD 53 214-66-6734 JUN, 25, 1956 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Inpopartment of Health and Mental Hygiene.

Department of Health and Mental Hygiene.

Inportant: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It of Marical Experiest must be notified at once. 1 ☐ Yes 2 No GWYNN MD **Funeral Director** BAITO. 10g. Citizen of What Country? 10e. Street and Number Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Never Married 2 ☐ Married 1 □ Yes 2 📶 No Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working lile. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OpeRATOr FACTOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( JACOBS MARY HLEX JACOBS ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) JACOBS-MOTHER CHEFTY Saltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State -Andsdowne, Md Cem ZION 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility PARKET FUNERAL 21. Signature of Funeral Servin Licen BAHO, MD. 21229 Frederick 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ASPIRATION HUURS PNEUMONIA Sequentially list conditions, if my leaf the immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner CHRONIC Physician: The law requires that the death certificate be executed DRUG burial-transi 24 HOURS Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐Yes 2 ☐ No P.O. detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No Vital 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To of 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident n 24 hours after death le Funeral Director: / bletely filled in by the f 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier completely and manner stated. the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANTHONY SUNG,

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

EASTERN

AVENUE

BATIMORE, MD

4940

mD

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of D **Physician** MILLAR LORES /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Seasons Hospice Randallstown Birthplace (State or Foreign Country)
 TN 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 🖫 F Hours 59 April 19, 1950 Director <u> 214–56–</u>4488 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f show Department of Heatth and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, Ite Wedich Exambra must be notified at 1 ☐ Yes 2 🛣 No Director MD Baltimore Randallstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code within 72 hours after death with U.S.A. 3923 McDonogh Road 21133 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🛣 No Specify ò 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within lealth and Mental Hygiene. m 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Beautician Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Moles Silvester Hurley Mary ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3923 McDonogh Road Randallstown, MD Keith R. Millard Husband 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Mem Park 7/14/09 Sykesville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road J. Wayne Osterling ELINE FUNERAL HOME Reisterstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day signed by the a d be detached fo 5 ☐ Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been si page 2 shoufd b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate funeral director, pag 1 □Yes 2 No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) Hospice Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No ithin 24 hours after death.

the Funeral Director: A

mpletely filled in by the fu death. 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. within 7 29b. Signature and title

Registrar
DHMH 17 Rev 1/2001

State

30. Name

31. Date filed (Month, Day, Year)

and address of person who completed

ause of death (Item 23a) (Type, Print)

21215-0036

29b. Signature and title of certifier

Hasmile

Director

Funeral

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Be Completed

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Be Completed by Physician/Medical Examiner

Medical Certification: To

**Physician** 

/Medical

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I're Modical Exeminer must be routified at any injury or other traumatic event, I're Modical Exeminer must be routified at any once.

<ul> <li>State Registrar</li> </ul>		aryland / Depa <i>Cer</i>	tificate of		Reg. No	0000	2236
. Decedent's Name (First, Midd	le, Last)				Date of Death     Month     Date	y Year	3. Time of Death
MERTON		MASON			July 10	2009	1 07:05 AM
a. Facility Name (If not institution	n, give street and number	)	10 110	or Location of Death	J 40	. County of Deat	h
Social Security Number	150 150 17. A	ge (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9 Birt	N/A hplace (State or Foreigi
073-26-9425 sual Residence of Decedent	1 M 2□F	79 Yrs.	Months Days	Hours Min.	(Month, Day, Year 06/30/193	)   Co	NY
a. State 10b. Count		10c. City, Town or Loc					10d. Inside City Limits
MD BALT	IMORE	HUNT V	ALLEY				1 □ Yes 2 No
e. Street and Number	OUDT #440 T		10f. Zip Code		10g. C	itizen of What Co	untry?
400 SYMPHONY C	12. Was Decedent			030	asifu Va a ar Na	USA	viana la dian
. Marital Status  1 Never Married 2 Ma 3 Widowed 4 Divorce	Armed Forces?  ried 1 X Yes 2 □  If Yes Give	No LODE A	Yes, specify Cul	Hispanic Origin? (Spoan, Mexican, Puerto  Specify:	ecity Yes of No- Rican, etc.)	14. Race - Ame Black, White Specify: Wh	
15. Decede	nt's Education		ent's Usual Occu	pation during most of work	16b. H	(ind of Business/	Industry
Elementary/Secondary (0-12)	College (1-4or	5+) Iife. D	O NOT use retire	ed)			
. Father's Name (First, Middle	(act)	CERTIF	IED PUBI	IC ACCOUN	ITANT AC	COUNTING	<u> </u>
JULIAN	MASO	NNI				,	DI FILL
OUL I AN  a. Informant's Name/Relation			Address (Stree	JULIE	al Route Number, City		DDL EMAN
ABBY MASON /	WIFE	400 S	YMPHONY	COURT, #4	48-D. HUNT	VALLEY	MD 21030
a. Method of Disposition 1		20b. Place of Dispos cemetery, crema BALTIMORE				ocation - City or	
. Signature of Funeral Service	Licensee	I .	Name and Addr	. 50	L LEVINSON D., PIKESV		
3a. Part 1. Enter the disease, of shock, or heart failure. Lis nmediate Cause (Final sease or condition sease or condition soulting in death)	a. Rit	ine.		ing, such as cardiac			Approximate Interval Between Onset and Death
equentially list conditions, any, leading to immediate use. Entir Underlying ause (Disease or injury at initiated events sulting in death) Last	с	a consequence of):					
	d	7-11-					
FEMALE:  Bb. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown		2 ☐ Fetal death 3 ☐	Ectopic pregnan Other (specify)	су		23d. Date of del Month	ivery Day Year
rt II. Other significant conditi	ons contributing to death b	out not resulting in the und	derlying cause gi	ven in Part I.	23e. Did tobacco	. /	the cause of death?
					24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of
Was case referred to medica				26. Place of Deatl	1 Tyes 2 2 No	1 □Yes	2 ANO
examiner?	Hospital: 1 Inpati	ent 2 ER/Outpatient	3 □ DOA Ot	hor:	me 5 ☐ Residence	6 ☐ Other (Spec	cify)
Manner of Death 1 Natural 5 ☐ Pendi	28a. Date of Inju	ury 28b. Time of	28c. Inju Wo		28d. Describe how inju		
2 Accident Invest							

**Physician** /Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the aftending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

> 5 State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Hospital

Baltimore

29c. License number

29d. Date signed (Month, Day, Year) 2009

MO

RES-000

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

Hasmila Sinoni mo

Artumanyon, Y 31. Date filed (Month, Day, Year)

29c. License number

Auare

Kes 00000

Drive

29d. Date signed (Month, Day, Year)

Baltimore, Md 21337

07.09.2009

State Registrar

one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar's Signature

S NADIGER M.D 30. Name and ed thiss of person who completed cause of death (Item 23a) (Type, Print)

SHRIVATSA NADIGER M.D. 9000 Franklin

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 _ State	of Marylan		epartment of H C <i>ertificate of L</i>			0.0	ng	22358
			Registrar  1. Decedent's Name (First, Middle, Last)			20111110410 01 2		2. Date of Dea		<u> </u>	3. Time of Death
	Physicia /Medic		Grace Ann Par	ks				Month July	Day 11, 20	Year 109	5:47 P M
	Examin		4a. Facility Name (If not institution, give street and	number)		4b. City, Town, or	Location of Death		4c. County	of Death	
page 1			Greater Baltimore Med			Towson	If Under 24 Hrs.	La Barata	Balti		lane (Chairman Familia)
	Funeral Director		5. Social Security Number 212–50–0106 6. Sex	7. Age (In yrs.	<i>l</i> as <i>t birthi</i> Yr	Months Days	Hours Min.	8. Date of Birt (Month, Da) Oct. 24	, Year) , 1948	Maru	lace (State or Foreign stry) Land
-	D		Usual Residence of Decedent					000. 21	, 1310		
	srylan show	_	10a. State 10b. County			or Location				1	0d. Inside City Limits
:	28a-f	Director	Maryland Baltimore	Pho	enix				10 0:4:41	VIbrat Cour	1 ☐ Yes 2 No
3	23a or 3		14021 Jarrettsville	Pike		10f. Zip Code	131		10g. Citizen of V	SA	ury :
5-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. At of Health and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examination in last to notified a	by Funeral	1 Never Married 2 Married 1 Yes,	ecedent Ever in U. Forces? s <b>XX</b> No Give r Dates:	S.	13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes XX No	spanic Origin? (S n, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)		e - Americ k, White, c : <b>Whit</b>	etc.
0-612	within /2 hor liene. r than "naturi in Moleal I	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College	d) e (1-4or 5+)	16a. D	ecedent's Usual Occupi Give kind of work done of ife. DO NOT use retired	ation Juring most of work )	king	16b. Kind of Bu	usiness/Ind	dustry
. A	riled w Hygier other th	ပိ	11 17. Father's Name (First, Middle, Last)			Waitress	18. Mother's Nam	no (First Middle	Resta	auran	t
/land	2 should be in and Mental H is marked ot raumatic ever	To Be	Murray Myers II					aide C.			
Mar	auma		19a. Informant's Name/Relationship (Type. Print)		19b. N	Mailing Address (Street a					Code)
≥ . ```	l and Health sm 27 ther to		Roger Atkins Son		llage of D	1379 Wanda		Hanover,	PA 1733		un Stata
saltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai		20a. Method of Disposition  1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from	all State		Disposition (Name of crematory or other place	i			•	
	artme ortani injury		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Fy eral Service Licensee	At	\	cic Cremator 22. Name and Addres	s of Facility			3.5	Maryland
ñ	any per	2 14	Jum B. D	Jenss		Burgee-Hens 3631 Falls	ss-Seitz Road, Ba	Funeral altimore	Home, I	Inc. and	21211
			23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause o	at caused the deat n each line.	n. Do no	t enter the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
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, ,	incate be executed physician and is the burial-transit			to (or as a conseq	uence of)	:					
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י ק	d by t	Phy	9 ☐ Unknown  Part II. Other significant conditions contributing to		ulting in t	he underlying cause give	an in Part I	23e Did to	hacco use cont	ribute to th	ne cause of death?
records, P.O. Bo	en signe	ed by	_ myelodysplast	ic Sy	ndr	ome				3 ☐ Prot	<b>\</b>
ec c	has be	Completed		J				24a. Was autop	sy	prior to co	psy findings available mpletion of cause of
VITAL	ficate r, pag							1 □ Yes	2 No	death? 1 ∐Yes	2 □No
5	s certi	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1	Inpatient 2□	EB/Outp	ationt 3 DOA Othe	or.	th (Check only o		(0	
101	ter this	j.i	27. Manner of Death 28a. Da	tte of Injury	28b. Tin	ne of 28c. Injury			ow injury occurr		y)
VISION	eath. or: Af	catic	2 Accident investigation				Yes 2 □ No				
	after d	Certification: To	determined 286. Pla	ice of Injury - At ho ilding, etc. (Specif	ome, farm y)	n, street, factory, office		28f. Location (S City or Tow	Street and Numb n, State)	er or Rura	il Route Number,
and of	within 24 hours after death,  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one)  (Check only one)  1 Certifying Physician: To 2 Medical Examiner: On the and medical Examiner.								
r d	withir comp	Me	29b. Signature and title of certifier	)		29c. License	number		29d. Date signe	d (Month,	Day, Year)
			manh for W	4,1	10	200	5808	2	7/12	109	
	3		30. Name and address of person who completed c	ause of death (Item	23a) (Ty	(pe, Print) St S	wite 55	ON-PA	William	Tows	0h MD
	Sta Registra		31. Date filed (Month, Day, Year) 32	. Registrar's Signa	ture			1 / 0	A THUIL		,

DHMH 17 Rev 1/2001

_		3	For State Registrar			te of Ma	ırylanı	_	artment of rtificate of				Reg. No.	2009	22	369
	Physici		1. Decedent's Nam		, Last)	DADL	~					. Date of De Month	Day	2009	3. Time of	f Death M
	/Medic Examin		4a. Facility Name (	13			0		4b. City, Town,	or Location of De		1017	40.0	County of Death		
			BALTIMORE 5. Social Security N	WASHIN	GTON 1	MEDICA	12 C	ENTER	GLE	N BUR	AL6	3			LUNDE	
	Funeral Director		5. Social Security N 218-28-9		6. Sex 1 <b>X</b> M 2	7. Aye	79 (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	in. 8	Date of Bir (Month, Da 04/09	th ay, <i>Year)</i> /1930	Co	hplace (State ountry)  WV	or Foreign
	ס		Usual Residence o	of Decedent					<u> </u>			04/03	71750	<u>'                                    </u>		
	death with the Maryland ims 23a or 28a-f show	7	10a. State	10b. County			10c. City	y, Town or Lo							10d. Inside C	ity Limits 2 No
	the M 28a-f	Director	MD 10e. Street and Nu		ne Aru	ndel			Gle	n Burnie	5		10a Citiz	en of What Co		-20110
	3a or	Ö		dy Driv	ဥ				Ton Elp Godo	21061			70g. 0		.S.A.	
	death	Funeral	11. Marital Status	<u>uj 2221</u>	12. Was	s Decedent E ned Forces?	ver in U.S	S. 13.	Was Decedent of If Yes, specify Cut		(Speci	fy Yes or No	o- 1-	4. Race - Ame		
36	s after ; or ite	by Fu	1 Never Marr		ed 1 🗆	]Yes 2 ∏ N es. Give	Ю		1 ∐ Yes 2√∏tNo		011011	oan, o.o.,		Chesifu	nite	
J. 5-0036	hour	ed b	3 Widowed	15. Decedent	's Education	r or Dates:		16a. Dece	dent's Usual Occu	pation			16b. Kin	d of Business/l		
215	hin 72 e. an "na Media	Completed	(Spec	cify only highes	t grade compi	leted) lege (1-4or 5-	+)	(Give	kind of work done DO NOT use retire	during most of ved)	vorking				•	
27	ed wit ygien <b>ver th</b> :	Con	11				,		Superv					ndwich	Compan	ıy
Maryland 212	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Widen Event in a 12 b. mult of a nonce.	Be	17. Father's Name Harry A							18. Mother's N	lame (	First, Middle.	, Maiden S	Morela	and	
31	should nd Me mark imatic	2	19a. Informant's N			nt)		19b. Mailir	ng Address (Stree	t and Number or	Rural I	Route Numb	er, Citv or			
3,5€	and 2 alth a 27 Is		Mrs. Jo	an Park	er / w	ife		411	Cody Dri	ve, Gi	Len	Burni	e, Ma	ryland	21061	
PARKER altimore, N	es 1 a	1 3	20a. Method of Dis	sposition Cremation	3 □ Bernoval	from State	20b. P	lace of Dispo emetery, crei	sition (Name of matory or other pla	ace)	Dat	e	20c. Loc	ation - City or	Γown, State	
A.R. tim	t. Pag rtment rtant:		4 Donation	5 ☐ Other (Sp	pecify)		At		Cremato			2009		n Burn		
Bai	permi Depar Impor any ir		21. Signature of Fu	uneral Service I	Licensee		Ma		2. Name and Addr ingleton	-		2nd Av	-		n Burni	
			23a. Part 1. Boter 1	the disease, or	complications	that caused	the death							Betvie	Approxima:	te
	Physician		Immediate Cause disease or condition	<del>art f</del> ailure. List o (Final on		e on each lin		CEE	ici ou						Onset and	Death
	/Medical Examiner		resulting in death)		D	ue to (or as a	a consequ	uence of):	100.501/1:						* 1 1 1 1	
		ē	Sequentially list co	onditions,		4304 OF SE			70 AM	COME					SAED	<u>as</u>
118	be executed sician and burial-transit	Examiner	Sequentially list contany, reading to in cause. Enter Under Cause (Disease or that initiated events	erlying r injury s	c.											
50,	ate be exe hysician a the burial-t	EX	resulting in death)	Last	D	ue to (or as a	a consequ	uence of):								
98760	icate l physic	dical			d										· · · · · · ·	
Box 6	leath certific attending p	n/Me	IF FEMALE: 23b. Was deceden	nt pregnant		es, outcome o							2	3d. Date of del	ivery	
	requires that the death certificate seen signed by the attending phys nould be detached for use as the	Physician/Me	in the past 12 1 ☐ Yes 2 [	2 months? □No	4 🗆	Live birth Pregnant at Unknown			☐ Ectopic pregnar ☐ Other <i>(specify)</i> .	icy				Month	Day	Year
P.0	that the de ned by the a detached i	Phys	9 Unknown					daine in the co		han in David		220 Did	tob once we	se contribute to	the course of	doath?
ds,	signe d be d	l by	Part II. Other signi						, , ,	venin Fatti.			Yes 2□			Unknown
cor	w requir been s should	letec	ter to to		~~~	1 1021	<b>677</b>	able of	~ P		_	24a. Was			topsy findings	
Be	The law cate has b page 2 sl	Completed	-				·				_	auto perfo	psy ormed?	prior to death?	completion of o	cause of
ital	ysician: Thi is certificate director, pag	Be C	25. Was case refer examiner?	rred to medical						26. Place of D	Death (	1 □Yes Check only o		1 ∐ Yes	2 No	
of V	S S	၉	1  Yes 2		Hospital	1 M Inpatie		ER/Outpatier	IL 3 LI DOA					☐Other (Spec	cify)	
on (	ding J. After fune	tion:	27. Manner of Deat	th 5 ☐ Pending investig	g	Date of Injur (Month, Day	y , Year)	28b. Time o Injury	Wo	uryat ork? ⊒Yes 2 □ No	28	d. Describe	how injury	occurred		
Division of Vital Records,	l or Attending after death. Director: After I in by the funer	ifica	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could n	ot be	Place of Inju	ry - At ho	me, farm, str	eet, factory, office		28			Number or Ru	ıral Route Nur	nber,
اق	p # 12 =	Certification:	4 🗀 Homicide			building, etc	. (Зресп)	y) 			4	City or To	wn, State)			
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one)		Examiner: Or		examina		h occurred at the vestigation, in my							s)
	To the within To the Comp	Me	29b. Signature and						29c. Licer	se number			29d. Date	signed (Month	h, Day, Year)	
			▶ Ghi	Brus	des gran	د عموم	ND		Do	063+14	۲		20,	Cd 112	1000	
	3		30. Name and add		,	•	`		*				1			
	Sta	te	31. Date filed (Mon		- /	32. Registra	r's Signat	ture	HOSPITAL	L DRIVE	10	Fh Bl	IRPI	E' WD 3	DIC!	
	Registr	4	HH.	1 4 20	119 04	near	p.	19 an								

DHMH 17 Rev 1/2001

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Amend #State of What Pland / Department of Health and Mental Hygiene

			For State Registrar	end "State of Wa	ar <del>ytand</del> /	Department Certificate			ygiene Reg. No. ? A A C	00070
			1. Decedent's Name (First, Mic	ddle, Last) Flora El	izabetl			2. Date of D	Death	3. Time of Death
	Physici		Flora	<i>P</i>	1-1	3 ina		Month	Day Year 9 2 00 9	
24	/Medio Examin		4a. Facility Name (If not institu			4b. City, 1	Town, or Location	n of Death	4c. County of Dea	ath
1			Charlestown	Retirement C	enter		Catonsvi		I	Baltimore
	Funeral		5. Social Security Number	6. Sex 7. Age	e (In yrs. last b	Months	1 Year If Under Days Hours	er 24 Hrs. 8. Date of E Min. (Month, I	Birth 9. Bi Day, Year) 0	rthplace (State or Foreign Country)
	Director		219-18-5376 Usual Residence of Decedent	1□M 2∏ F	86	Yrs.		Sep. 2	20, 1922 N	Maryland
	land ow		10a. State 10b. Cour	ity	10c. City, Tox	wn or Location				10d. Inside City Limits
	Mary -f sh	ğ	MD Ba	ltimore		Cato	onsville	2		1 □Yes 2 <b>X</b> No
	n the	Director	10e. Street and Number			10f. Zip			10g, Citizen of What C	ountry?
	th with	<u>a</u>	707 Maiden C	hoice Lane, A	pt. 9G-	-21	21228		United	States
	ems	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S.	13. Was Decede	ent of Hispanic C	Origin? (Specify Yes or Nan, Puerto Rican, etc.)		erican Indian,
36	72 hours after death with the Maryland "natural", or items 23a or 28a-f show idlest Examinate be redified at	by Fu	1 Never Married 2 M	If Yes, Give	No	1 □Yes 2			Specify:	White
Ö	fural"		3 Widowed 4 Divorc		16	a. Decedent's Usua	LOggunation		16b. Kind of Business	
15	in 72 in mai	olete	(Specify only hig	ent's Education hest grade completed)		(Give kind of work life. DO NOT use	k done during mo e retired)	ost of working	Tob. Killa of Busilless	5/11Idusti y
212	within jiene.	Completed	Elementary/Secondary (0-12 12	) College (1-4or 5	+)	Homemak			Own H	Iome
ď	be filed within 72 ho ital Hyglene. id other than "natu event, Ital Modelled	Be C	17. Father's Name (First, Midd					her's Name (First, Midd	le, Maiden Surname)	
/lar	thould be and Mental marked o	To E	John Callaha	n				Dorothy Gre	en	
Maryland 21215-0036	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relatio						ber, City or Town, State,	
	and lealth m 27 her tr		George Pfetzi	ng - Husband		/07 Maide	n Choice	Ln., Apt.	9G-21, Cato	onsville, MD
Baltimore,	Pages 1 nent of H int: If Iter iry or oth	1	20a. Method of Disposition 1 X Burial 2 ☐ Crematio	n 3 Removal from State	20b. Place cemet	of Disposition (Nam ery, crematory or oti	her place)	Date	20c. Location - City o	r Iown, State
ij		1	4 Donation 5 Dother	11	Wood	Lawn Cemet	terv	7-11-2009	Woodlawn,	MD
Ba	permit. Departr Importa any inju	1	1. Signalute of Luneral Servi	19 Company	141	122. Name and	Address of Fac	Ambrose I	Funeral Home	e, Inc.
			23a. Part 1. Enter the disease,	or complications that caused	the death Do	not enter the mode	of dving such:	pring Kd.,	Arbutus, M	21227 Approximate Interval Between
	Dhysisian		shock, or heart failure. L Immediate Cause (Final	ist only one cause on each lin	ne.		,	,	,	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as	a consequence	Organ	ra	ilure		
	Examiner			540 10 (0) 40	a concoquence	3 01,1				
	D +	ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	Due to (or as	a consequence	e of):				
	ecuter nd transi	Examiner	that initiated events	с						
90,	be exician a	ũ	resulting in death) Last	Due to (or as a	a consequence	e of):				
68760,	ificate be executed g physician and as the burial-transit	edical		d						
	D 5. 6		IF FEMALE:	23c, If yes, outcome	of pregnancy				22d Data of d	olivory
Box	eath atter for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal dea				23d. Date of d Month	Day Year
0	that the death cer	Physician/M	1 □ Yes 2 □ No 9 □ Unknown	9 ☐ Unknown						
ď.	s that ined b	γ	Part II. Other significant cond	itions contributing to death bu	ut not resulting	in the underlying ca	use given in Par	t I. 23e. Die	d tobacco use contribute	to the cause of death?
ğ	The law requires that ate has been signed b age 2 should be det	Completed by	Pysphag	ia				1	]Yes 2. Ino 3. I	Probably 4 ☐ Unknown
ဝ၁	aw re as be 2 sho	plet	Ruptured	divertic	uli v	with Ab	scess	24a. Wa	s an 24b. Were a	autopsy findings available completion of cause of
<u>~</u>	The ate h	Ĕ	Lymphon					pei	formed? 🌙 death?	es 2 \( \subseteq No
/ita	ician: The certificate ector, pag	Be (	25. W case referred to medi- examiner?	cal			1	ce of Death (Check onl)		
£	Physician: r this certific ral director, I		1 Yes 2 1√10			Outpatient 3 DO			sidence 6 Other (Sp	pecify)
Division of Vital Records,	Ing F	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pend		ry y, Year)   28b.	Time of 28 Injury M	3c. Injury at Work?		e how injury occurred	
isi	ttend death stor: / the /	icat	3 ☐ Suicide 6 ☐ Cou	stigation Id not be 28e Place of Inju	irv - At home		1 ☐ Yes 2 [		(Street and Number or F	Pural Pauta Number
i≥	after Direct Jin by	Certification: To	4 ☐ Homicide dete	building, etc	(Specify)	farm, street, factory,	Onice	City or T	own, State)	nurai noute Numbei,
	Or the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 ☐ Certif	ying Physician: To the best of	of my knowled	ge, death occurred	at the time, date	and place, and due to the	ne cause(s) and manner	as stated.
	he Mc in 24   he Fu pletel	Medical	(Check only 2 Medic one)	al Examiner: On the basis of and manner sta	f examination a	and/or investigation,	in my opinion, d	eath occurred at the tim	e, date and place, and du	ue to the cause(s)
	To t. Withi To tl	Ź	29b. Signature and title of certi	ler a		29c.	License numbe	r	29d. Date signed (Mor	nth, Day, Year)
			Cleneer	Benli	nu	$\mathcal{D}$	4437	7	7/9/0	09
			30. Name and address of person	on who completed cause of de	eath (Item 23a	) (Type, Print)	01 -	1	0 /	11 21238
			Deneen Box 31. Date filed (Month, Day, Yea	win, mb	ar's Signature	aiden	Choice	e Lane,	Cartonsvil	le, mo
	Sta Registr		HII 1 4 2	ing denew	J. A	are				

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Vear Physician $P^{M}$ James Edgar Ryan J111 v 2009 5:11 /Medical O 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min 1⊠ M 2□ F Months Davs Hours Director 218-32-6392 75 June 27, 1934 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examination in the notified at Director 1 ☐ Yes 21 No Maryland Harford Abingdon 10f. Zin Code 10e. Street and Number 10g. Citizen of What Country? USA Funeral 3126 Abingdon Road 21009 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Bace - American Indian. Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐Yes 2 ☑No Specify ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If item 27 is marked other the any injury or other traumatic event, Inc. Once. Field Technician 12 U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Carroll Ryan ပ Anna Agusta Bensor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen E. Ryan / Wife 3126 Abingdon Road, Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 2 Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Lut. Ch. Cem. 7-15-09 Joppa, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. (us 1317 Cokesbury Rd., Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician s a consequence of): Unknown disease or condition resulting in death) /Medical Examiner Respiratory Failure ercapherc enterous Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 🗆 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760,<sup>(</sup> attending physician þ

with the Maryland

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore,

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

Medical 29b. Signature and title of certifier

29c. License number

ceenawall MO

4 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0060248

J.C. Greenawalt, MD

29d. Date signed (Month, Day, Year) July 11, 2009

North Charles Street 31. Date filed (Month, Day, Year)

Baltimore . Registrar's Signature

State Registrar

124

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 2009 Physician William Ray 6:56  $\triangleright$  M July 11 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Frederick Memorial Hospital Frederick Frederick 8. Date of Birth (Month, Day, April 3 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 247-46-394 12 M 2□ F Months Hours 78 S. CAROLINA Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Its Medical Eventral must be redified at once. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State MD FREDERICK FREDERICK 1 Z Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? BARTONSVILLE RD USA 21704 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No \$ Specify. Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION FOREMAN - CONCRETE FINISHU 4TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be TOBEY RAY CARRILL JOHNSON ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELLEN 6027 ABARTONSVILLE RO FLOD. MD 21704 RA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State RESTHAVON MOM. GAR, JULY 18, 2009 GROD. MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility GARY L. ROLLIUS FUN. VIONG suy d. FREDERICK MD 110 WEST SOUTH ST 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heartfailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of: disease or condition resulting in death) /Medical Examiner Sequentially list conditions, it any control to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page 1 □ Yes 2 1 No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar 29b. Signatu

Konis

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

400

WEST 2. Registrar's Signature

m RSA

DHMH 17 Rev 1/2001

Doo6 1210

29d. Date signed (Month, Day, Year) 7/11/09

21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dolores Rios 9, 9:00 AM July 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 813 Dorchester Rd. 21229 Baltimore, MD. 8. Date of Birth Jan. 12, 1914 Puerto Rico 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 X F Months Days Hours 583-12-7622 95 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits Maryland N/A ?7 Is marked other than "natural", or Items 23a or 28a-f sh traumatic event, the Wadical Evaninar must be natified Baltimore Director 1 XYes 2 No 10e. Street and Number 813 Dorchester Rd. 10f. Zip Code 21229 10g. Citizen of What Country? USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: Puerto Rican 3altimore, Maryland 21215-0036 X Yes 2 No Specify: Hispanic If Yes, Give Year or Dates: \$ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental Ventura Rios Raimunda Berrios ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 813 Dorchester Rd. Baltimore, MD. 21229 19a. Informant's Name/Relationship (Type. Print)
Raimunda Davila, daughter Department of Health a Important: If item 27 Is any Injury or other trau once. 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Cemetery, crematory or other place)
Glen Haven Memorial Park 07-13-09 20c. Location - City or Town, State Glen Burnie, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 3 years **Physician** connective hert disease or condition resulting in death) /Medical Due to as a consequence of): Examiner Inronic abstructure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-transf Exami and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 📉 No Month Day Year 5 ☐ Other (specify) the 9 Unknown 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 XYes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate perform 1 ☐ Yes 2 No 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ★ Residence 6 ☐ Other (Specify) 1 Yes 2 No Certification; To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Injury death. 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

Division of Vital Records, P.O. Box 68760 ithin 24 hours after death.

the Funeral Director: A

mpletely filled in by the fu To the within 7

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D0055820 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pobert WROSS 11055 Little Paxuet Pake Suite 209, Columbia, MO 21044 Robert WROSS

State Registrar

Medical

29a. Certifier (Check only one)

31. Date filed (Month, Day,

32. Registrar's Signature

Important: If tiem 27 is marked other than "natural", of items 23a of 28a+ show any injury or other traumatic event, the accompleted any injury or other traumatic event, the accompleted by Funeral Director	MD I	s Hospi ber 6.5	re street and numb	obinsc er)	on			July 6,	2009		13:05	- N
neral ector	Holy Cros 5. Social Security Numb 577–46–555 Usual Residence of De 10a. State 10	s Hospi ber 6.5	tal Gex 7.	er)								
ector	5. Social Security Numb 577-46-555 Usual Residence of De 10a. State 10	ber 6. S 58	Sex 7.				r Location of Dea	ıth		ounty of Death ntgome:		
ector	577–46–555  Usual Residence of De  10a. State  MD  E	58 1 cedent		Ane (In vrs	last birthday)	Silver	Spring   If Under 24 Hr	S. 8 Date of Bir				r Foreid
n must be notified at	MD 10a. State 10		<b>A</b>	75	Yrs.	Months Days	Hours Mir		4, 19	33 D	place (State o untry) .C.	
ar must benotiff ineral Direct		ob. County Prince (	George's		y, Town or Lo						10d. Inside Cit	
ar must be	10e. Street and Number					10f. Zip Code			10g. Citize	n of What Cou	untry?	
ar mu	3600 Jeff	Road				20	785		U.S			
	11. Marital Status		12. Was Decede		S. 13.	Was Decedent of H	Hispanic Origin? (	(Specify Yes or No erto Rican, etc.)		. Race - Amer		
Exemin by Fu	1 ☐ Never Married 3 ☐ Widowed 4 ☐		1 □Yes 2 If Yes, Give Year or Date	No		1 ⊡Yes 2 Mg No		no moan, etc.)		African-American		
t, the the denie	(Specify	. Decedent's Ed	ducation ade completed)		16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	pation during most of w	orking i	16b. Kind of Business/Industry			
mpl	Elementary/Seconda		College (1-4	or 5+)	Recre	DO NOT use retire Pation Sp	<sup>ⅆ)</sup> ecialist		Gove	rnment		
CO CO	17. Father's Name (Firs	st. Middle I act	4					ame (First, Middle,	Maiden Si	ırname)		
c even	Maurice Ro		/					ggie Duck		,,,,,,,,,,		
To	19a. Informant's Name		Type. Print)		19b. Mailir	ng Address (Street		Rural Route Numbe		own, State, Z	ip Code)	
r trau	Emma B. Ro					•		gdale, MD	-		,	
or othe	20a. Method of Disposi	ition			lace of Dispo	sition (Name of matory or other place Cenetery	1	Date	20c. Loca	tion - City or T		
Jury	4□Donation 5[		··	ידדו					20018	•		
iny ir	21. Signature of Funer	al Service Lice	nse9 00		22   <b>F</b>	2. Name and Addre	ess of Facility  & Assoc.	. Funeral			28th St	
ne burial-transit	Sequentially list condition by leading to inner cause. Enter Underlyin Cause (Disease or injuthat initiated events resulting in death) Last		С	as a consequ	, , , , , , , , , , , , , , , , , , ,							
for use as the	IF FEMALE: 23b. Was decedent proint the past 12 mo 1 ☐ Yes 2 ☐ N 9 ☐ Unknown	nths?		h 2 ☐ Feta nt at time of c	I death 3	☐ Ectopic pregnand	су		236	d. Date of deli Month		<b>/</b> ear
<b>6</b> B	Part II. Other significa Myelodysp				ulting in the u	nderlying cause giv	ven in Part I.				the cause of d	
should	Malnutrit	ion. ar	nemia					24a. Was			topsy findings	
a D		•				······································	·	<ul> <li>autor</li> </ul>	osy ormed?	prior to death?	completion of c	ause o
Be C	25. Was case referred	to medical					26. Place of D	eath <i>(Check only o</i>		1,0163	2.310	
al direc	examiner? 1 ☐ Yes 2 ☑ No				ER/Outpatier		4 LI Nursing	Home 5 ☐ Resid			cify)	
completely filled in by the funeral director, page.  Medical Certification: To Be Complete to the complete that the comp	2 Accident	Pending investigation  Could not be determined	n 28e. Place of	Day, Year)	28b. Time of Injury	Wor	ry at k? ]Yes 2 □ No	28d. Describe l	Street and I		ral Route Num	ber,
pletely filled edical Ce				is of examina				ice, and due to the curred at the time,				;)
сошр	29b. Signature and title	of certifier	111			29c. Licens D679				signed (Month		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 8<sup>Day</sup> **Physician** ROTTMAN JUĽŸ LEE 2009 3:00 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c, County of Death Examiner SEASONS HOSPICE @ NORTHWEST HOSPITAL BALTIMORE RANDALLSTOWN 8. Date of Birth 12/29/1914 Birthplace (State or Foreign Country)

Output

D Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Months 1 □ M 2 X F Days Hours Min. 94 Director <u> 258-12-4587</u> Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examinar mast burnstiffed and once. 1 □Yes 2 No Funeral Director MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16 OLD COURT ROAD, 21208 #418 USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Completed by Specify: WHITF 3 X Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LAZARUS ABRAHAM KALIN ZELDA မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARNOLD ROTTMAN / SON 2900 STONE CLIFF DRIVE, #211, BALTIMORE, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State Benation 5 ☐ Other (Specify) BETH EL MEMORIAL PARK: 07/10/2009 RANDALLSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., Signature of Funeral Su e Licensee 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner de Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Normal (Specify) 1 ☐ Yes 2 DA 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation thin 24 hours after death.

the Funeral Director: A mpletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a, Certifier 1 🖵 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year)

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type

32.

registrar's Signature

31. Date filed (Month, Day, Year)

09-05368
Heidi Elizabeth Steck

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

+		1- For State Certificate of Deat	th	Re	g. No. 200	9 2237
Physic Medical Exam	ian/	Decedent's Name (First, Middle,Last)		2. Date of Death Month July 8, 200	Day Year	3. Time of Death 1020 hrs
			Town, or Location of Dea	ath	4c. County of Death Baltimore Cou	
Funeral Director		197-66-1635 1_M 2XF 22 Yrs. Month	der 1 Year   If Under 24H hs   Days   Hours   M	8. Date of Birth	Cou	hplace (State or Foreign untry) nnsylvania
any A		Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location				10d. Inside City Limits
Aaryland  28a-f show	tor	Maryland Baltimore Cockeysvill  10e. Street and Number 110f. Zig			011	1 Yes 2 X No
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens I hand matural", or items 23a or 28a-f sho injury on other transmatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 10f. Zip 13 Watkins Glen Court	21030	10	g. Citizen of What Cour USA	ury ?
ath with	Funeral	1 X Never Married 2 Married Armed Forces? If Yes, speci	ent of Hispanic Origin? ( ify Cuban, Mexican, Puer	Specify Yes or No- rto Rican, etc.)	14. Race - Ameri White, etc.	can Indian, Black,
after de al", or	by Fu	or Dates:	No specify:		Specify: Whi	te
5-0036 led within 72 hours after lygiene, other than "natural", other than "natural", the Medical Examiner		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual during most of wo	l Occupation (Give kind o orking life. DO NOT use r		16b. Kind of Business/I	ndustry
5-0036 lled within 7 Hygiene. I other than the Medical	Completed	12 Clerk			Card Sho	p
215-C e filed v al Hygi ced otho	Be Co	17. Father's Name (First, Middle, Last)  Todd Steck		me (First, Middle, M a Ann Sch		
e, MD 2121: and 2 should be fill thealth and Mental I item 27 is marked traumatic event,	TOE	19a. Informant's Name/Relationship (Type, Print )	s (Street and Number of	or Rural Route Num	ber, City or Town, State	' '
y, MC and 2 s lealth au tem 27		Laura Ann Steck, Mother 13 Watkin 20a. Method of Disposition 20b. Place of Disposition (Nat	is Glen Cour	ct Cockey:	sville, Mar 20c. Location - City or	yland 21030 Town, State
Baltimore, permit. Pages I an Department of Hea Important: If iten		1 Burial 2 X Cremation 3 Removal from State crematory or other place 4 Donation 5 Other Specify:	′	7/10/09	Baltimore,	Maryland
Balti permit. Departm Imports		21. Signature of Funeral Service Licentee Thomas Gregor 22. Name and Cremat	Address of Facility ion Society ederick Roa	Of Mary	land, Inc.	1 01000
Physician		23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode failure. List only one cause on each line.	of dying, such as cardia	c or respiratory arre	ore, Maryla st, shock, or heart	Approximate Interval Between Onset and
/Medical xaminer		Immediate Cause (Final disease or condition resulting in death)  a Acute alcohol, fluoxetine  Due to (or as a consequence of):	& lorazepa	am intoxi	cation	Death
		Sequentially list conditions, b				
	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Levents resulting in death.) Last Due to (or as a consequence of):  Due to (or as a consequence of):				
ecuted and - transit		d.				
760, ficate be executed g physician and the burial - transi	Medica	X UNPENDED 23a,27,28a-f,perM	正,g893 //2 ————	23/09 TT		
x 6876 h certificat tending ph		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (See	3 Ectopic preg	gnancy	23d. Date of delivery  Month	Day Year
Box e death c the atten	Physician	1 Yes 2 No 9 V Unknown Unknown	ecify)			
Division of Vital Records, P.O. Box 68' the Hospital or Attending Physician: The law requires that the death certifind Faheral Director: After this certificate has been signed by the attending rupletely filled in by the funeral director, page 2 should be detached for use as	ğ		g cause given in Part I.	purent,	pacco use contribute to	
of Vital Records,  ng Physician: The law require ther this certificate has been si neral director, page 2 should b	Completed			24a. Was a		topsy findings available completion of cause of
Recc The lav icate ha	Somp			perform	med? death?	
Vital Recaysician: The this certificate I director, page	o Be (	25. Was case referred to medical examiner? [Hospital: 1 Inpution 2 FB/Outpution 3	26.Place of Death (Chec		Residence 6 🗸 Other	: Scene
1 of \ding Phy ting Phy After the	-	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work?		ow injury occurred	
Division tal or Attendians after death.	Certification:	Pre-religing Fd 7/8/09 Fd 10:12 att 28e. Place of Injury - At home, farm, street, factory			treet and Number or Ru ate) I3_Watkii	ral Route Number, City
DIVI: Hospital or 24 hours after Funeral Directly filled in b	Certi	Suicide 6 A Could not be determined (Specify) house  29a. Certifier A Could not be determined (Specify)		or Town, St Cockey	sville, MD	is GLen Ct
Divis To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.				
To with	Me		O.C.M.E.		29d. Date signed (Mo. July 9, 2009	nth, Day,Year)
Ø v		30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, I	Baltimore, MD 212	201	<del></del>	
S	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	•			
Regis		JUL 14 2009 Server B. Jacks	,			<del></del>

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09-04874 Sheila Sanders

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State of Maryland	/ Department of He	ealth and Mental F	-Ivaiene

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oriella Sarider.	3	1- For State Continuation of Department of Health and Mental P		2005	3 2237
Physic	cian/	1. Decedent's Name (First, Middle,Last)	2. Date of Death		3. Time of Death
Medical Exan		Sheila Lynn Sanders	June 20, 20	Day Year 009	0633 hrs
)		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Dear	th	4c. County of Death	
		Doctors Community Hospital Lanham		Prince George	
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24Hi		(MM/DD/YYYY) 9. Bir Foreig	gn
Directo	"	249-15-3036 1 M 2X F 46 Yrs.	3-21-19	63 <sup>co</sup>	ountry) SC
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
*					1 Yes 2 X No
Maryland 28a-f show	햟	MD Prince Georges College Park  10e. Street and Number 10f. Zip Code	T 100	g. Citizen of What Cou	ntry?
e Ma or 28	Director	9014 Rhode Island Avenue 20740		USA	,
vith th	<u> </u>	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (	Specify Yes or No-		ican Indian, Black,
eath v	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puert		White, etc.	,
fter d	E	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify: Afri	can-American
ours a atura	ğ	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re		16b. Kind of Business/	Industry
6 172 h	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	sureu)	Prince Geor	ge's
5-0036 iled within 7 Hygiene. I other than	II É	Volume 1		County Gove	
filed Hyg	ပြ		ne (First, Middle, M	aiden Surname)	
2121 2121 Suld be fi Mental	To Be	Lerov Sanders Julia  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or	Mazuck r Rura Route Numb	er City or Town State	Zin Code)
MD 2 nd 2 shou lith and 1 m 27 is r	-	Betty J. Sanders/Sister 6914 RealPrincess Lane. Gu		•	, <u>L.p 0000</u> ,
and Sand Sealth		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City or	Town, State
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If fire m 71 is marked other than "natural", or items 23a or 28af sho		1 X Burial 2 Cremation 3 Removal from State crematory or other place)  Salters Cerretery 6-	-27-09	Cross, Sout	h Camlina
lit. Partme		4 Donation 5 Other Specify:  21. Signature of Funeral Service Licensee 22. Name and Address of Facility			
Balti permit. Departr Import		9200 LibertyRoad, Rance			
Physicia	n	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
/Medica		failure. List only one cause on each line.  Immediate Cause (Final disease a. Complications of parasellar meningio	ma		Death
amine	'	or condition resulting in death)  Due to (or as a consequence of):			
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	i e	cause. Enter Underlying Cause			J
K .	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and compleately filled in the fineral director and a stepland the deathed for use as the burial.	la E	d.  AMENDED 23a,2/,perME, g893 7/15/09 TT	•		-
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Box 687 e death certific the attending p	icia	past 12 months?  4 Pregnant at time of death 5 Other (Specify)			
Bo le dear the a	Physician/	1 Yes 2 No 9 V Unknown g Unknown			
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F V. Physical distribution	ြို	1 Yes 2 No	-	Residence 6 Othe	r: 
n of ding Ph. h. After i	Ë	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	200. Describe no	ow injury occurred	
SiO Atten r deat	Cati	2 Accident Investigation 28e Place of Injury - At home farm street, factory office building etc.	28f Location (St	reet and Number or Ri	ural Route Number, City
Sala garage	Certification:	Suicide Could not be determined (Specific)	or Town, Sta		arai (Cotte Namber, Ony
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending To the Funeral Director: After this certificate has been signed by the attending the hope of the funeral director mass 2 should be described.	၂ မ	29a. Certifier	nd due to the cause	(s) and manner as stat	red
thin 2	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred			
F 3 F 8	₹	and manner stated.  29b. Signature and title of certifier  29c. License number		29d. Date signed (Mo	nth, Day, Year)
		O.C.M.E.		June 21, 2009	
		30. Name and address of person who completed cause of death (Item 23a)			
		Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2120	01		
	State				
Regi		JUL 14 2009 Common p. Aller			
DHMH 17 Rev 1 OCME 2006	/2001	ORIGINAL	OCME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tem 2 Rerydoc 2893 7-29-09 Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2040 4c. County of Death Edward Nelson Sutton /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Franklin Square Hospital Baltimore Rosedale venter If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/26/1925 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number 6 Sex **Funeral** Days Hours Min. Maryland 1**XX**M 2□ F 83 218-14-9332 Director Usual Residence of Decedent death with the Maryland 10d Inside City Limits 10b. County 10c. City, Town or Location th and Mental Hygiene. 77 is marked other than "natural", or Items 23a or 28a-f show traumatic event, Ite II-sifed Examinar must be notified at 1 ☐ Yes 2ÃÃNo Director Maryland Baltimore Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21221 U.S.A. 2340 Turkey Point Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status should be filed within 72 hours after and Mental Hygiene. 1 Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2No Specify: 2 Specify: 3 X Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Construction Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward Sutton **Emma** Wolf ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Heatth an Important: If Item 27 is r any Injury or other traur once. Darlene Sutton (Daughter-in-law)411 Haslett Road, Joppa, Maryland 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XX remation 3 ☐ Removal from State Bayview Crematory, Inc. 07/11/2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 21. Bignature of Fur eral Service Lectrisee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part — Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Stenosi Hortic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trans resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မှ 27. Manner of Death 1 X Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide e Funeral C 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier ical (Check only To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) am, ed hwy 718109 D006 1907 10

Registrar DHMH 17 Rev 1/2001 Ave nue

, Butmore, MD 21221

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Chukwuna Ebo

JUL 1 4 2009

31. Date filed (Month, Day, Year)

1124 Mace

32. Registrar's

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Year Day Nelson Edward Sutton 100 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death cam If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/24/1953 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 <del>Q</del> M 2 □ F Months Days Hours Min 217 62 6042 56 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 ☐ No Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 411 Haslett Road 21085 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Never Married 2 Married 1 □Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Purchaser Mobile Office/Trailer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Nelson Sutton Short Louise 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Sutton (wife) 411 Haslett Road Joppa Maryland 21085 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 4r⊡ Donation Bayview Crematory Inc 7/14/2009 Baltimore Maryland 21. Schatte of Juneral Service Licen 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex Maryland 21221 23a. Part 1. En er the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat se (Final disease or condition resulting in death) rooressive Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) □Yes 2□No 9 | Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 ∠ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a. Was an autopsy periormed? Yes 2 ☐ No 1.120 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

**Physician** /Medical Examiner

Examine

Completed by Physician/Medical

Be

Medical Certification: To

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

Director

Funeral

<u>6</u>

Completed

Be (

ortant: If Item 27 Is marked other than "natural", or items 23a or 28a-f sho Injury or other traumatic event, Its Medical Examination in difficing

permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene.
Important: if Item 27 1s marked other than "natural", or items; any Injury or other traumatic event

NelsonESuttoi

Baltimore, Maryland 21215-0036

signed by the attending physician and I be detached for use as the burial-trar page 2 s

P.O. Box 68760,

Division of VItal Records,

certificate director, this funeral After

or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fu the Hospital

State Registrar

31. Date filed (Month, Day, Year)

JUL 1 4 2009

29b. Signature and title of certifier

1☑Yes 2☐No

5 ☐ Pending investigation

6 ☐ Could not be

determined

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

4 ☐ Homicide

(Check only one)

MENUCCI, MD

28a. Date of Injury (Month, Day, Year)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

RES-00 07/10/2009

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARIA B. HENUCCU-Good Samaritan Lock Raven Bird - Baltimore . 21239 - Mary land 5601

e. Registrar's Signature

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

09-05345 Willie Lee Simmons

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2	0	0	9	2	2	3	8

		1- For State Registrar	Certificat	e of Death	Re	g. No.	22306
Physicia Medical Examir		Decedent's Name (First, Middle, Last)     Willie Simi	nons		2. Date of Death Month July 7, 200	Day Year 19	3. Time of Death 1700 hrs
		4a. Facility Name (if not institution, give street at 4110 Woodhaven Avenue	nd number)	4b. City, Town, or Location of De Baltimore	eath	4c. County of Death	VA
Funeral Director		5. Social Security Number 6. Sex  222-84-3868 1 M 2  Usual Residence of Decedent	7. Age (In yrs. last birthda		Hrs. 8. Date of Birt Min. Aug.	h(MM/DD/YYYY) 9. Birt Foreigi Cou	
land f show any once.	Į.	Mayland N/A	10c. City, Town or	Baltimore			10d. Inside City Limits 1 Yes 2 No
eath with the Maryland ritems 23a or 28a-f show ust be notified at once.	Director	410 Woodhaven A	2rd Flow	10f. Zip Code 21216	10	g, Citizen of What Coun	4
hours after death with the Maryland "natural", or items 23a or 28a-f sh Examiner must be notified at once	by Funeral	Never Married 2 Married Arrival 1 1 3 Widowed 4 Divorced If Yes Given or Dates:	ed Forces? Yes 2 No e Year	3. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pure 1 Yes 2 No specify:	erto Rican, etc.)	White, etc. Specify: Black	nck_
2	Completed	15. Decedent's Education (Specify only highes  Elementary/Secondary (0-12)  Colle		cedent's Usual Occupation (Give kind ing most of working life. DO NOT use		16b. Kind of Business/II  Self-em	played
	Be Co	17. Father's Name (First, Middle, Last) Wille Simmons		18.Mother's N	ame (First, Middle, M Dougla:		
MD 21 d 2 should lth and Me n 27 is ma	٦[	19a. Informant's Name/Relationship (Type, Print Alice Simmons—A	nother 3	Mailing Address (Street and Number	pt D B	affimore 1	largland
Baltimore, MD 2121 permit. Pages I and 2 should be fi Department of Health and Mental i Important: If item 27 is marked injury or other traumatic event,		20a. Method of Disposition  1		pisposition (Name of cemetery, or other place)  Cemetery  22. Name and Address Facility	Date 7/17/09	20c. Location - Oily or Landsdown	Town, State  Maylard  Plantage
		23a. Part I. Enter the disease, or complications to	hat caused the death. Do not e	3512 Frederick	Arc Ba	HMOR Ma	ryland pproximate Interval
Physician /Medical Examiner	1	failure. List only one cause on each line.  Immediate Cause (Final disease a Hangin		, , , , , , , , , , , , , , , , , , ,			Between Onset and Death
	_    -	Sequentially list conditions, b.	as a consequence of):				
	Examiner	cause. Enter Underlying Cause	as a consequence of):				
execut an and al - tra		d. UNPENDED X AMEND	EDT +#10	FH,G893,7/14/09,W			
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Leichie   Le	yes, outcome of pregnancy	Fetal death 3 Ectopic pre Other (Specify)		23d. Date of delivery Month D	ay Year
i, P.O. B ires that the d signed by the	হ	Part II. Other significant conditions contribut	ing to death but not resulting in	the underlying cause given in Part I.		pacco use contribute to t	
cords law requ has been	Completed				24a. Was a autops perform	y prior to co n <u>ed</u> ? death?	opsy findings available ompletion of cause of
Vital Rec ystclan: The his certificate director, page	o Be (	25. Was case referred to medical examiner?	Inpatient 2 ER/Outp	26.Place of Death (Che atient 3 DOA Other		Residence 6 🗸 Other:	Scene
sion of V  trending Phy death.  ctor: After th	-1	1 Natural 5 Pending FO	Date of Injury Youth, Day, Year) IND: FOUNI 7, 2009 1553 h	ne of Injury 28c. Injury at Work? D: 1 Yes 2 ✓ No	28d. Describe h Subject hang	ow injury occurred ged self	
Divis pital or At ours after d eral Direc filled in by	Certification	4 Homicide Could not be determined (Spe	Place of Injury - At home, farm ecify) Multi-Family Apt.	, street, factory, office building, etc.	or Town, St	treet and Number or Rur ate) ven Avenue , Baltimo	
To the Hos within 24 h To the Fun completely	ledical	one) 2 Medical Examiner: On the b		occurred at the time, date and place, estigation, in my opinion, death occurre			
	Ž	29b. Signature and title of certifier	1. H	29c. License number O.C.M.E.		July 8, 2009	th, Day,Year)
			cause of death (Item 23a) edical Examiner 111	Penn Street, Baltimore, MD	21201		-
Sta Regista	200	31. Date filed (Month, Day, Year) 3  JUL 1 4 2000	2. Pegistracs Signature	Sale			
DHMH 17 Rev 1/20		- 7 4000	ORIG	CN C		OCME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** ZELDA SILVER MAN 10:15 A M JULY 2009 O /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TRANSITIONS SYKESVILLE CARROLL HEALTHCARE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. 04/04/19 19 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F Months 90 214-40-5554 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is fractice. Examine must be notified and any injury or other traumatic event, it is fractice. 1 ☐ Yes 2 X No Director BALTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21208 USA 807 JUDY LANE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify. Specify: WHITE 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) SOCIAL STUDIES SUPERVISOR EDUCATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LOUIS BRENNER RAY ပ KLOTZMAN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) NANCY SEFF / NIECE 8002 IVY LANE, BALTIMORE, MD 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State HEBREW FRIENDSHIP 07/12/2009 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Funeral Service Licen 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that calcold the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEVERE PULMUNARY HYPERTENSION disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner Due to (or as a consequence or) If any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transi and P.O. Box 68760, Due to (or as a consequence of) the attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Dav 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, EFFUSION 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2: autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ical (Check only one) ner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title occritier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 1838 GREENE TREE ROAD #300 PILESVILLE LEONARD RICHARDSON M.P.

32. Registrar's Signature

JUL 1 4 2009 Benen B. Jack

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 10 Physician 2009 SHILING **JULY** PEARL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE GILCHRIST HOSPICE OF BALTIMORE TOWSON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/04/1919 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days Months Hours Yrs. 90 Director 213-01-6560 Usual Residence of Decedent 10h County 10c. City, Town or Location 10a. State 23a or 28a-f show Injury or other traumatic event, the Hedical Examinar must be notified at Director N/A **BALTIMORE** MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3704 N. CHARLES STREET, #1501 21218 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any Injury or other traumation. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE ģ 3 ₩ Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ SOCIAL WORKER PUBLIC HEALTH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ISRAEL NEIMAN **ESTHER** ೭ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARGARET SHARFSTEIN / DAUGHTER 6 E. BISHOPS ROAD, BALTIMORE, MD\_21218 20c. Location - City or Town, State 20b. Place of Disposition (Name of ARICATINGT GINNA TOTAL) THE POLICE 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) AMUNO CONGREGATION 07/12/2009 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature of Funeral Service Ligenses 8900 REISTERSTOWN RD., PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Nervous system Cymphoma Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Examine Be Completed by Physician/Medical

32. Registrar's Signature

31. Date filed (Month, Day, Year,

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregnancy  1	23d. Date of delivery Month Day Year
Part II. Other significant conditions of		Did tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown  Vas an utopsy findings available prior to completion of cause of death?
25. Was case referred to medical examiner?	1 □ Ye  26. Place of Death (Check or  Hospital:  Other:	as 2-No 1 Yes 2 No
1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28b. Time of   28b. Injury at   28d. Description	Residence 6 Other (Specifical Action of the
3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At nome, farm, street, factory, office   28i. Location	on (Street and Number or Rural Route Number, Town, State)
	nysician: To the best of my knowledge, death occurred at the time, date and place, and due to niner: On the basis of examination and/or investigation, in my opinion, death occurred at the ti and manner stated.	
29b. Signature and title of certifier	Jest License number 525205	29d. Date signed (Month, Day, Year)  7. (7 10, 2009
30. Name and address of person who	completed cause of death (Item 23a) (Type, Print)  Chules St. R	ratto and zizox

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

4:58 A

Birthplace (State or Foreign Country)
 MD

**PLEWER** 

10d. Inside City Limits

Approximate Interval Between Onset and Death

minter

1 X Yes 2 ☐ No

DHMH 17 Rev 1/2001

7

State Registrar

Medical Certification; To

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day 7. 200 PMM SILBERSTEIN MILTON 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death BALTIMORE BALTIMORE COURTLAND GARDENS g. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 1172271916 Months Days 1X M 2□F 212-01-3258 92 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 □ No BALTIMORE MD N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2110 WESTERN RUN DRIVE 21209 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No Specify Specify: WHITE 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 OWNER HARDWARE STORE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HENRY SILBERSTEIN BERTHA BENESH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARK SILBERSTEIN / SON 2110 WESTERN RUN DRIVE, BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON CHIZUK AMUNO 07/09/2009 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN RD., PIKESVILLE, MD west 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final U year disease or condition resulting in death) Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo (or as a nonsequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an performe 1□ Yes 2 N 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 | No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 3 ☐ Suicide

Examiner Examine the Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical Division or Vital Records, P.O. Be Completed by Certification: To After within 24 hours after death

To the Funeral Director:
completely filled in by the

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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l or ms 23a (must b

"natural", or iten dical Examiner

permit. Pages 1 and 2 s
Department of Health an
Important: If item 27 is 1
any Injury or other trautonce.

**Physician** 

/Medical

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be မ

6 □ Could not be

29a. Certifier

4 Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar

6

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Erwin azew /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Joseph Richey Hospice If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2 □ F 53 217-64-5916 Director 12/30/1955 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Exercitor coust by notified at 1 XYes 2 ☐ No Director Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21201 U.S.A. 838 N. Eutaw Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Insurance Insurance Broker 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Alease Grant Taylor A. Tazewell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 900 Honeywood Place, Baltimore, MD 21221 Iris Tazewell/ Sister Department of Health Important; If item 27 any injury or other to once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/14/2009 Hanover, Maryland Anatomy Gifts Registry 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Solvice Livensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) Physician/Medical attending pl IF FEMALE: Box yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Month 5 Other (specify) 1 □ Yes 2 □ No. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed/ 1 ☐ Yes 2 No 2 🗆 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 State (Specify) 1 Yes 2NZ No HOUDIC 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To completely filled in by the funeral 27. Manner of Chath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation death, 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - Brown

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

philips

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per the 8893 7-30-09 Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 9, July Anna U. Vickers 2009 10:25 A M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Keswick Multicare Center Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 21 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 XF 88 215-16-2981 2009 Maryland Director Feb. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State t be notified at 10b. County 1√XYes 2□No Maryland N/A Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with 1423 Medfield Avenue 21211 USA "natural", or items 23a dical Examiner must b Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Black, White, etc. 1 Never Married 28 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXIo If Yes, Give Year or Dates: Specify. þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed withi Health and Mental Hygiene. em 27 is marked other than Librarian Pratt Library the 12 traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bartholomew Unsoeld Regina permit. Pages 1 and 2.
Department of Health an.
Important: If item 27 is m. any injury or other 2. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Vickers Husband 1423 Medfield Avenue, Baltimore, Maryland 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Lorraine Park Cemetery 7/13/2009 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign ture of Funeral Service Licen: 22 Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 3631 Falls Road, Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ementia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) and resulting in death) Last Due to (or as a consequence of) burial-Box 68760, physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the 9 Unknown 9 Unknown signed by the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Colonic - Vaginal 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 this certificate has autopsy 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 1 ☐ Yes 2 ☐ No Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ I Director: After this d in by the funeral or 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide filled 24 hours a 📹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifler DAM 102

Registrar

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State

CHAYLES

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DON M.D.

5901

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1:58 P M 2009 Mary Ellen Van Dusen July. 1. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore 1400 Edmondson Avenue Catonsville 8. Date of Birth (Month, Day, Year)
April 16,1927 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days 1 M 2 X F Hours Min. Michigan **Director** 368-22-3081 82 Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examinating must be notified at 1 ☐ Yes 2X No Director Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 1400 Edmondson Avenue USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify. White þ Specify. 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick Rademacher Ruth Burdick ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn Stone Daughter 1400 Edmondson Avenue; Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 8-27-2009 Arlington National Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Survice Li 1630 Edmondsn Avenue; Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between 5 Months Immediate Cause (Final **Physician** G disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed, within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending the funeral director. Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 XYes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 □Yes 2 1 ☐ Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∭TNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one)

Registrar DHMH 17 Rev 1/2001

State

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29b. Signature and title of certifier

E W COLE 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ST AGNES 900 CATON AVE BALTIMORIE MD

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29d. Date signed (Month, Day, Year)

	1	For State Registrar	State o	f Marylar	nd / Depa <i>Cei</i>	artmen rtificate	t of H e of L	ealth and Death	Mental Hy	giene Reg. No.	111111	22387		
		Decedent's Name (First, Middle, L.)	ast)						2. Date of De Month	ath Day	Year	3. Time of Death		
Physicia		Norman	Watts	Sr					July	9	2009	8:40p <sup>™</sup>		
/Medica Examine		4a. Facility Name (If not institution, g	ive street and nu	mber)		4b. City,	Town, or	Location of Dea	ıth	1	County of Dear			
Examine		Holy Cross Hosp						Spring			Montgom			
Funeral			Sex	7. Age (In yrs	. last birthday)	If Under	1 Year Days	If Under 24 Hr Hours Mir	(Month, D	rth a <i>y, Year)</i>	9. Bir	thplace (State or Foreign ountry)		
Director		220-07-4348	1 <b>2</b> M 2 □ F	90	Yrs.	Monard			Feb. 2	, 19	19	MD		
	t	Usual Residence of Decedent				-1:						10d. Inside City Limits		
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or 28	<u>S</u>	10e. Street and Number				10f. Zip				Tog. Cit				
th wit	Funeral Director	4414 Dery Rd.					)772		10 10 14		USA 14. Race - Am	prican Indian		
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or its		1 Never Married 2 Married	If Yes, G	ive No 19	943-	1 □ Yes	2 🔀 No	Specify:			Specify:	Black		
ours ours	d b	3 ☐ Widowed 4 ☐ Divorced	Year or D	Dates:	1945	dent's Usu	al Occur	ation		16b. K	ind of Business	/Industry		
72 h	ete	15. Decedent's (Specify only highest of	Education grade completed)	)	(Give	kind of wo	rk done	during most of w	rorking			·		
han eithin	Completed	Elementary/Secondary (0-12)	College (	(1-4or 5+)		1ste		-/		Me	etro			
led w tygie her t		7th 17. Father's Name (First, Middle, La			Орис	<u>, 1500</u>		18. Mother's N	ame (First, Middl	e, Maiden	Surname)			
be fill that It ad out	Be		31)					Sarah	Johnson					
Lally identified a 12.13.10000 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show sumatic event, the "hadical Evan" or items to rutified a sumatic event, the "hadical Evan" or must be rutified.	မ	Henson Watts	(Time Print)		19h Maili	ing Addres	s (Street	and Number or	Rural Route Num	ber, City	or Town, State,	Zip Code)		
National States of the second		19a. Informant's Name/Relationship				4 Der			oer Marl					
I ey, Ividal yidailu Z IZ IZ DOOOO  1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene it feet an arked other than "hatural", or items 23a or 28a-f show other traumatic event, the "Adical Evan in a rust be redffind at		Allie D. Watts	- MIIE	20b.	Place of Disponentery, cre				Date		ocation - City o			
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Datitinole, ma permit. Pages 1 and 2 s Department of Health at Important: If item 27 is any Injury or other tran		4 □ Donation 5 □ Other (Spe			vetera	ans U	eme t	ery   7-2	20-2009			, 123 (		
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205 40		23a. P. rt 1. Enter the disease, or c	0-1	0200				land Rd			FIG. 20	Approximate		
		shock, or heart failure. List of	omplications that nly one cause on	each line.	atti. Do not ei	ite: the mo	do or dy	ng, odon do odre	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			Interval Between Onset and Death		
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/Medical		resulting in death)		o (or as a cons								1		
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<b>68 / 60,</b> tificate be ex ng physician as the burial	dical		d	mra or										
box 6870 death certificate to death certificate to attending physical for use as the box 600 death of the box 600	Me	IF FEMALE:	230 If yes c	outcome of preg	nancy						23d. Date of o	lelivery		
<b>BOX</b> eath cer attendin for use	ian/	23b. Was decedent pregnant in the past 12 months?	1 Liv	e birth 2 Fe	etal death 3	☐ Ectopic		су			Month	Day Year		
he de	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Un		ordeam 5	Other (	apcony,							
Cords, P.O.  w requires that the described signed by the should be detached	Physician/Med	Part II. Other significant condition	s contributing to	death but not r	resulting in the	underlying	cause g	iven in Part I.	23e. D	d tobacco	use contribute	to the cause of death?		
Signe	by	Dementia	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						11	Yes	2 🔯 No 3 🗆	Probably 4 ☐ Unknown		
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vision of Vital F Attending Physician: The orderh. ector: After this certificate by the funeral director, pag	Be (	25. Was case referred to medical examiner?	111						Death (Check on					
hysic his c		1 Yes 21X No		NInpatient 2			DOA	4 🗆 1401511	ng Home 5 ☐ R		6 UOther (S jury occurred	pecify)		
ng Pl	ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	/8.4	ite of Injury Jonth, Day, Year	28b. Time njury		28c. Inj We	uryat ork? ⊒Yes 2.⊒No	Zou, Descri	DE HOW IN	jury occurred			
endil endil eath. or: A	cati	2 Accident investig			L-23				28f Locatio	n (Street	and Number or	Rural Route Number,		
Division of Vital I or Attending Physician: 1 after death. Director: Atter this certifica d in by the funeral director, p	Certification: To	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 28e. Pla	ace of Injury - A ilding, etc. (Sp	t nome, tarm, : ecify)	street, lacti	эгу, описе	,	City or	Town, Sta	ate)			
Divisic  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the 1				M	lum quad a de a de	ath coour	ad at the	time date and r	place, and due to	the cause	e(s) and manne	r as stated.		
Hosp 4 hou Tune ely fil	cal	(Check only 2 Medical I	Examiner: On the	e basis of exan	nination and/or	investigat	on, in m	opinion, death	occurred at the ti	ne, date a	and place, and	due to the cause(s)		
To the Hospital within 24 hours a To the Funeral completely filled	Medical	one)	and m	anner stated.			29c. Lice	nse number		29d. l	Date signed (M	onth, Day, Year)		
wit Cor	[	29b. Signature and title of certifier						5148		7-	-9-2009			
		Lary			<u> </u>		כע	7140		,	, 2007			
hy		30. Name and address of person		ause of death (	Item 23a) (Typ	e, Print)		11 770 °C	oring M	n. 20	1902			
2		Delroy Anglin	, _MD 1	500 For	est Gle	en Kd	. S	TIVEL 2	pring, M	<i>D</i> • 40	3,02			
Sta Regist		31. Date filed (Month, 1997)	£ 2009	2. Fegistrar's S	1.	bare	1							

Clifton Wissner

11:50 р.ш.

July 10, 2009

			1 - State Registrar		Ce	rtificate of L	Death		Reg. No.	9 22300	
	Physici	0.00	1. Decedent's Name (First, Midd	fle, Last)				2. Date of Dea		3. Time of Death	
	/Medic		Clifton Cha	arles Wissner	·			July 10		11:50P M	
	Examir	ner	4a. Facility Name (If not institution	on, give street and number)		4b. City, Town, or	Location of Death		4c. County of I	Death	
أسمليد			Stella Maris			Tows			Balto.		
	Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last birthday 87 Yrs.	If Under 1 Year   Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da		Birthplace (State or Foreign Country)	
	Director		220-01-3802 Usual Residence of Decedent	11	<b>O</b> ,			July 24	4,1921   N	Maryland	
	yland		10a. State 10b. County	у	10c. City, Town or L	ocation				10d. Inside City Limits	
	Mar Mar	햦	Md. Ba	alto.		Notting	ham			1 □ Yes 2X No	
	or 28	Director	10e. Street and Number	I.L.U.		10f. Zip Code	паш		10g. Citizen of Wha	t Country?	
	th wit		9 Rosehill (	St.		21	236		USA		
	ems	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No-	- 14. Race -	American Indian, Vhite, etc.	
ဂ္ဂ	or it	by Fu	1 Never Married 2 Ma	rried 1 ∏es 2 □ l If Yes, Give	No	1 □Yes 2 □ No	Specify:	7 110411, 0101,	Specify:	White	
215-0036	ural"		3 Widowed 4 □ Divorced	d Year or Dates:	1942-1945						
ŗ	n 72 i "nal	Set	(Specify only highe	nt's Education est grade completed)	16a. Dece (Give	edent's Usual Occupa e kind of work done d DO NOT use retired,	ition uring most of work	ing	16b. Kind of Busin	ess/Industry	
717	withi iene. <b>thar</b>	Completed	Elementary/Secondary (0-12)	College (1-4or 5	Labor				Bethleher	n Steel	
0	ifiled I Hyg other	Be C	17. Father's Name (First, Middle	, Last)		-	18. Mother's Nam	e (First, Middle,	Maiden Surname)		
land	uld be Aenta rked ric ev	10 B	Charles Wissne	e <b>r</b>			Mildred :	Smith			
ary	shou and N s ma	ļ-,	19a. Informant's Name/Relations	ship (Type. Print)	19b. Mail	ing Address (Street a			er, City or Town, Sta	te, Zip Code)	
, sa	is 1 and 2 is 1 kealth a item 27 is cother trau		JoAnn W. Willi	iams DTR.	12 H	Brook Farm	Ct. Pe	rry Hali	l, Md. 21	128	
ore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Madical Evar, that rough be notified at once.		20a. Method of Disposition  A□ Burial 2 □ Cremation	2 Demonal from State	20b. Place of Disp cemetery, cre	osition (Name of matory or other place	e)	Date	20c. Location - City	y or Town, State	
апп	Pag ment ant:		4 □ Donation 5 □ Other (8		Highview	J	7-18-	-2009	Fallston	, Md.	
<u>a</u>	permit Depart Import any in once.		21. Signature of Funeral Service	Licensee	2	2. Name and Addres	s of Facility S	chimunel	k Funeral	Home	
_	= @ O		Bun a	. Well	e					Md. 21236	
				or complications that caused t only one cause on each li	d the death. Do not er ne.	ter the mode of dying	g, such as cardiac	or respiratory ar	rrest,	Approximate Interval Between Onset and Death	
F	hysician		Immediate Cause (Final disease or condition resulting in death)	a. Lung Ca	ncer					Oliset and Death	
1	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):						
		-e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequence of):						
	urted d insit	Ë	cause. Enter Underlying Cause (Disease or injury) that initiated events	\$ 500.10 (01.00	a concequence or,						
,	exec in and ial-tra	Examiner	resulting in death) Last	Due to (or as	a consequence of):						
5	Attending Prystolan: The law requires that the death certificate be executed reach redath.  ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	cal		d							
8	rtifica ng ph as th	Medical									
Š.	leath certific attending p for use as f	JE.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		☐ Ectopic pregnancy			23d. Date of	delivery	
	e dea he at ed fo	sici	in the past 12 months? 1 □ Yes 2 □ No	4 ☐ Pregnant a		Other (specify)			Month	Day Year	
	ries that the de signed by the a I be detached I	Physicia	9 Unknown					I'm più			
֝֟֝֟֝֟֝֟֝֟֝֟֝֟֝֟֝֟֝ <u>֚</u>	rres the signe	by	Part II. Other significant conditi	ons contributing to death bi	ut not resulting in the L	inderlying cause give	n in Part I.	111		te to the cause of death?	
5	law require as been sig 2 should b	Completed						1 🗆 Y	′es 2 □ No 3 □	Probably 4 Unknown	
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ָם ק	n: Ir ficate r, pa		-						rmed? deat 2 <b>X</b> No 1 □		
5	nysician: The Is his certificate ha I director, page 2	Be C	25. Was case referred to medica examiner?  1 ☐ Yes 2 ☒ No	Hospital:		nt 3 DOA Othe	26. Place of Deat				
5 2	aing Phy h. After this funeral d	ا: <u>۱</u>	27. Manner of Death	28a. Date of Inju	ent 2 ER/Outpatie	of 28c. Injury	at Nursing Ho		ience 6 <b>X</b> 1Other (	Specify) HOSPICE	
5 :	ath.	atio	1 Natural 5 Pendir 2 Accident investi	ng ( <i>Month, Da</i> j Igation	y, Year) Injury	Work'	? es 2 □ No		,		
2	Arre ecto by th	ific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	not be 28e. Place of Injuring	ury - At home, farm, st c. <i>(Specify)</i>	reet, factory, office				r Rural Route Number,	
5	ra aft	Certification:	N	Building, etc	o, (openly)			City or Tou	ni, Siale)		
	tospi 4 hour uner ely fill		29a. Certifier 1 ☐ Certifyii	ng Physician: To the best of Examiner: On the basis of	of my knowledge, dear	th occurred at the tim	e, date and place,	and due to the	cause(s) and manne	er as stated.	
	Io the nospital of Attendin within 24 hours after death. To the Funeral Director: Aft completely filled in by the fur	Medical	X Nurse Pra	actitione and sta	ated.						
ř	0 4 with 10	2	29b. Signature and title of dertifie	0 0 0 0 0		29c. License	number		29d. Date signed (M	lonth, Day, Year)	
			475/010	Zenn		18149	192		1/13	12009	
•			30. Name and address of person			,			. ,		
	Stat		31. Date filed (Month, Day, Year)		DULANEY VA	LLEY RD.	TIMONIU	M, MD 2	L093		

DHMH 17 Rev 1/2001

State

JUL 1 4 2009

Registrar

pare

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Day Physician 2:50aM 07 09 2009 Robert Max Warner, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore

9. Birthplace (State or Foreign Country) 3835 Cherrybrook Road Randallstown 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 212-34-3201 1 M 2 □ F 7/14/1937 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 28a-f show injury or other traumatic event, the Medical Examinar caset by notified at 1 ☐ Yes 2 No Funeral Director Baltimore M) Randallstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or Pages 1 and 2 should be filed within 72 hours after death with 21133 USA 3835 Cherrybrook Road 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 by 1 ☐ Yes 2 ☑ No specify African-American 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Pepsi Bottling Company 11th Route Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bishop Walter Medison Warner Annabelle Morgan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Beverly J. Warner /Wife 3835 Cherrybrook Road Randallstown, Maryland 21133 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) <u> Lakeview Memorial Garden : 7/16/2009</u> Eldersburg, Maryland 22. Name and Address of Facility Wylie Fineral Homes P.A. of Balto. Co. 21. Signature of Funeral Service Licensee 9200 Liberty Road RAndallstown, Maryland 21133 23a. Part 1. Enter the disease, or complications that vaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each pack line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Dug to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, Due to (or as a consequence of): Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) Ö ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 - No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Amesidence 6 Other (Specify) 2 No 1 ☐ Yes 1 🗌 Inpatient 2 ER/Outpatient 3 DOA hours after death. Ineral Director: After this y filled in by the funeral d 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

<sup>Year)</sup> 4 2009

MA

2. Registrar's Signature

29c. License number

2401 WREVEDERE NE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#18perFH, G893, 7731709, WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician 2**00 दिं George Watson Walter U ULY /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON MEDICAL GLEN MINE BURNIE 8. Date of Birth (Month, Day, Year) nder 1 Year | If Under 24 Hrs. | 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Country) 1 🕱 M 2 🗆 F 224-52-0837 67 1942 Virginia Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show event, the Medical Examiner must be notified at Director Maryland | Anne Arundel 1 ∐Yes 21X No Glen Burnie 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? with , or items 23a or 21060 29 First Ave., Marley Park United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14 Race - American Indian Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ⊠Yes 2 □ No
If Yes, Give
Year or Dates: '65-'67 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🔯 No þ Specify: 3 Widowed 4 Divorced Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, I'm Medical Example. White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Baltimore, Maryland 21215-(Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Chemical Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nettie B. Carter Howard S. Walter ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary M. Walter / Wife 29 First Ave., Marley Pk., Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Pk. 2009 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) IF to rul Service Lic n ee 21. Signa 22. Name and Address of Facility
Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E. Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final WETASTATIL Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Dun to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, aftending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate performe 2 No 1 □ Yes 1 ☐ Yes 2 No director. Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **N**o 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral c 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Iniury death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ne and title of certifier 29b, Signa 29d. Date signed (Month, Day, Year) 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) pikal **501** 0 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar
DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

2009 22391

		1- For State Registrar			С	ertifica	ate of	Death				R	eg. No.				
Physici	an/	1. Decedent's Name									2	. Date of Dea Month	th Day	Year		Time of	
ledical Exami	ner	Kyle Patr	ick W	/ankmille	•						July 6, 2009 1324 hrs						
		4a. Facility Name (if r	not institutio	n, give street and n	umber)		4b. City, Town, or Location of Death						4c.	County of	f Death		
		University Ho	spital					Baltimore							N/A		
Funeral		5. Social Security Nu	mber	6. Sex	7. Age (In yr:	s. last birtl	nday)	If Under 1	_	If Under		8. Date of Bi	th(MM/I	DD/YYYY)	9. Birthpla	ace (Sta	te or
Director		217-35-00	12	1 <b>X</b> M 2 F	1	7	Yrs.	Months I	Days	Hours	Min.	March	30	1992	Foreign Countr	y) <b>N</b>	1D
		Usual Residence of D	Decedent								ll	mar or					
any			0b. County		10c. C	ity, Town	wn or Location								10	d. Insid€	City Limits
<b>*</b>		MD	Balti	imore		Lut	herv	ille							1	Yes	2 X No
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th wi	Funeral	11. Marital Status  1 Never Married	2 M:	arried Armed I	cedent Ever in Forces?	1 U.S.		Decedent of s, specify Q				cify Yes or No ican, etc.)	)-	White	- American , etc.	indian,	ыаск,
r dea or it	Fu			1 Yes	2 X No	0								0 15			
s afte ral",	by	3 Widowed	Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specifyr.  Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give									-11		Specify:	whi:		
hour natu	pa							st of working					100. F	and or bus	siriess/iriqu	istry	
36 in 72 han '	ple	Elementary/Secon	dary (0-12)	College	(1-4 or 5+)		Stud	lent						adu	cation	2	
with with the t	ompleted	17. Father's Name (F	Times Baladadla	l aat\		1	<del>J.u.</del>		Tac	D Mothor's	Nama /	First, Middle,	Maiden			<u>.                                    </u>	
filed Hygel of the	Ö	·							'					Surname)			
12 Id be Aenta nark	o Be	Ronald G  19a. Informant's Nam				104	Mailing	Address (S	troot.			Jo Fox	_	ity or Tour	State 7i	n Code)	
D 2 shou and N 7 is n	J.	Ronald G			athor	1	_	,						•		p code)	
md 2 and 2 salth .		20a. Method of Dispo		Killiller / I				on (Name o				nville,	20c	l ocation -	Z 9 City or Tov	wn State	
S 1 a of He If its			_	n 3 Removal	from State	cremat	ory or othe	er place)			July	11,09			•		•
Page Page nent ant: or ot		4 Donation 5			D	ulan				moria	al G	ardens	s  Ti				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygeric Homeral and I steem to Tris marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fine	Service	ense			22. Na	me and Add	ress c	of Facility	ı Ua	mo of	D	lanov	. Vall	0.4	Inc
<b>©</b> 50 1 1		Michael	Flac	) la			10	W. P	ad	onia	Rd.	me of	phiu	m. M	V 411 1D 21	093	Inc.
Physician		23a. Part I. Enter the failure. List only			caused the de	ath. Do no	t enter the	mode of dy	ing, s	uch as ca	rdiac or r	espiratory ar	est, sho	ock, or hea	irt /	Approxim	nate Interval
/Medical		Immediate Cause (Fi		16 7	le Ini	uries	3										eath
kaminer		or condition resulting			a consequenc												
		Sequentially list cond	ditions.	b													
	Examiner	if any, leading to imm cause. Enter Underl	nediate		a consequenc	e of):											
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recuted and ransit		events resulting in de	eath) Last	,													
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K 61 1 cert endir use a	cia	past 12 months?	_		nant at time of	fdeath 5		er (Specify)							,		
Box e death c the atten ed for us	Physicia	1 Yes 2 No	g Uni	known g Unki	nown			Di (=)	-								
ords, P.O. Box 68: w requires that the death certifi as been signed by the attending : should be detached for use as 1		Part II. Other signific	cant condit	ions contributing	to death but no	ot resulting	in the un	derlying cau	ıse giv	ven in Par	† I.	23e. Did t	obacco	use contri	bute to the	cause c	of death?
P.O. es that the igned by	d b											1 Ye	s 2 🗸	No 3	Probab	ly 4	Unknown
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To the Hos within 24 h To the Fur	Medical	one) 2 V N	Medical Exa	miner:On the basis		n and/or i	nvestigatio	on, in my opi	nion,	death occ	curred at t	the time, date	and pla	ace, and di	ue to the ca	ause(s)	
F % F 8	Me	29b. Signature and ti	tle of certife					29c. Lie	cense	number			29d.	Date signe	ed (Month,	Day, Ye	ar)
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		Name and address	ss of person	who completed ca	use of death (II	tem 23a)							٠				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 43 AM 2009 /Medical 4a. Facility Name (If not institution, give street 4b. City, Town, or Location of Death 4c. County of Death Examiner 7. Age (In yrs. last birthday) If Under 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, 6. Sex Year) **Funeral** 1 X M 2 □ F Months Days Hours Min. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the modical Examination of the provided that the second of the control of the con 1 □Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 1 and 2 should be filed within 72 hours after death with I Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or: Funeral da 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No If Yes, Give Year or Dates: Specify 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Be 2 19a. Informant's Name/Relationshi (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) OWNUTAN Department of Heali Important; If item 2 any Injury or other once. Pages 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Fungral Service Licenses 22. Name and Address of Facility Home Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) my /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last words Examiner Due to (or as a consequence of) attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760. The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy Day Year Month 5 ☐ Other (specify) P.O. I signed by the aid be detached to detached 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2: autopsy perform of Vital 2 No 1 ☐ Yes 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ္ 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
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of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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30. Name and address of person who completed cause

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State of Maryland / Department of Health and Mental Hygiene Tamara Lynn Prenatt-Wesley 1- For State Certificate of Death Reg. No Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Tamara Lynn Prenatt-Wesley Physician/ Month Day July 3, 2009 0646 hrs **Medical Examiner** Tamara 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Southern Maryland Hospital Center Clinton If Under 1 Year I If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Davs Hours Country)WI Director 23 Yrs 15. 1986 1 M 2 X F 388-96-8486 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County Yes 2 x No 23a or 28a-f show notified at once, or 28a-f shov District Heights Prince Georges Director 10g. Citizen of What Country 10f. Zip Code 10e Street and Number 20747 6916 Flag Harbor Drive 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death wit
Department of Health and Mental Hygiene.
Important I filem 27 is marked other than "natural", or items 2
injury or other traumatic event, the Medical Examiner must be a Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 x No Yes White Specify Yes 2 X No specify. If Yes. Give Year Divorced 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Disabled N/A 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Burk Be Samuel M. Wesley, Jr. Kathleena M. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Kathleena M. Wesley Mother 21155 15915 Dark Hollow Road Upperco, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Burial 2 X Cremation 3 Removal from State 7/11/09 Carroll Cremation Ser Hampstead, Maryland Donation 5 Other Specify: 22. Name and Address of Facility ignature of Funeral Service Licensee 11824 Reisterstown Road Reisterstown, MD ELINE FUNERAL HOME Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. Death /Medical Coaine intoxication Immediate Cause (Final disease kaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed X AMENDED #1,23a,27,28a-f,perME, g894 8/11/09 TT Physician/Medical tending physician a use as the burial - 1 X UNPENDED Box 68760. 23d. Date of delivery 23c. If yes, outcome of pregnancy 3 Ectopic pregnancy Year 23b. Was decedent pregnant in the Month Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 ✔ Unknown g Unknown s been signed by the should be detached for 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 ✔ Unknown ģ Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy certificate has b performed? death? ✓ Yes 2 1 V Yes No 26.Place of Death (Check only one) 25. Was case referred to medical Physician: Be examiner? Hospital: 1 Other<sub>4</sub> Nursing Home 5 DOA Residence 6 Inpatient 2 V ER/Outpatient 3 this မှ 1 Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death Certification: To the Hospital or Attending within 24 hours after death. Natural Yes 2X No Director: d in by the Pending Fd 7/3/09 Fd 6:25 am 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6916 Flag Harbor Dr DIstrict Heights, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be 3 Suicide residence determined (Specify) To the Funeral Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OGME July 4, 2009 O.C.M.E. 30. Name and address of person who complete cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Theodore M. King, Jr., MD. 31. Date filed Month, Pay Ye 2009 2. Registrar's Signature State

Registrar

09-05188 В

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	justi	State of Maryland / Department of 1-For State Certificate of Registrar	of Death	Reg. I	No. 200	19 2239
Physici cal Exam		1. Decedent's Name (First, Middle,Last)  Brian Ross Augusti		2. Date of Death  Month  Date of Death  July 1, 2009		3. Time of Death 1428 hrs
al Exam	mei	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
		1138 Bay Ridge Road	Annapolis	To Date of Display	Anne Arundel  MM/DD/YYYY) 9. Birt	halana (Stata or
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  unknown 2 F 28 Yr  Usual Residence of Decedent	If Under 1 Year If Under 24Hrs Months Days Hours Min		Foreig	
Aaryland 28a-f show any 1 at once	, io	10a. State 10b. County 10c. City, Town or Local Maryland Anne Arundel	Annapoli			10d. Inside City Limits 1 Yes 2 XXNo
n the Maryland 3a or 28a-f sho otified at once	Director	10e. Street and Number 1138 Bay Ridge Road	10f. Zip Code 21403	10g.	Citizen of What Cour	ntry?
and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygien and with the matural", or items 23a or 28a-f she erray 'r is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	Funeral	1 X Never Married 2 Married Armed Forces? If Yes 2 X No	Yas Decedent of Hispanic Origin? ( S Yes, specify Cuban, Mexican, Puerto		White, etc.	can Indian, Black, ite
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be filed within 7 ntal Hygiene. rked other than ent, the Medica		17. Father's Name (First, Middle, Last) unknown		e (First, Middle, Mai Fern Stoke		
should be filed within and Mental Hygiene. T is marked other that a natic event, the Med	o Be		ng Address (Street and Number or			, Zip Code)
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permit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traums		20a. Method of Disposition  20b. Place of Disposition  X Burial 2 Cremation 3 Removal from State crematory or of			Oc. Location - City or	Town, State
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certificate ector, page	Be C	25 Was case referred to medical examiner?	26 Place of Death (Check			
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Physi r this al dis		27. Manner of Death  1 Natural 5 Pending 7.1 - 1.00	1 Yes 2 No			
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Hospital or Attending Physi 24 hours after death. Funeral Director: After this tely filled in by the funeral dir	al Certification:	Suicide  4 Homicide  4 Homicide  Certifier (Specify)  Could not be determined  (Specify)  House	curred at the time, date and place, an	Annapoli: ad due to the cause(	s) and manner as sta	Ridge Rd.
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Funeral Director		218-68-7149 <sub>1XM 2F</sub>	(In yrs. las	n yrs. last birthday)  If Under 1 Year  If Under 24Hrs.  Months  Days  Hours  Min.					- 1 <sub>e</sub>				
Any		Usual Residence of Decedent  10a. State 10b. County	10c. City, 7	Town or Location	n						11	0d. Inside City Limits	s
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Vfaryla 28a-f d at or	Director	10e. Street and Number			10f. Zip Coo	de			10g. Citizen of What Country?				_
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2 hour	sted	15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5-		16a. Decedent's during mos	s Usual Occ st of working					Sb. Kind of Busin Spangler			
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212 uld be Menta marke c even	lo Be	Carl George Bevan: 19a. Informant's Name/Relationship (Type, Print )	5, 31		Address (S	Street a				r, City or Town, \$			_
MD d 2 shc lth and n 27 is		Jenny Catherine Burton		1198	Rock	Spr	ings		Conov	vingo, M	ID	21918	
Baltimore, MD 21215-0036 Deprnit. Pages I and 2 should be filed within 7. Deprnment of Heath and Wellerl Hygiene. Important: If liem 27 is marked other than injury or other traumatic eveot, the Medical		20a. Method of Disposition  1 Burial 2 X Cremation 3 Removal from State	te cr	ace of Disposit ematory or other	er place)			Date	Lι	oc. Location - Cit √est Che	•		
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of Vital Records, ng Physician: The law requir Uffer this certificate has been s	Completed	(						-  _;	autopsy perform <u>e</u>	prior d? deat	to con	pletion of cause of	
		25. Was case referred to medical			26.P	lace of	Death (Ch	1 🗹 `neck only one)	res 2	_No 1 <b>✓</b>	Yes	2 <u>N</u> o	_
Vita hysicis this ce	To Be	examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatien	t 2 E	R/Outpatient			hor:	ursing Home 5	Res	sidence 6 🗸 C	ther: S	cene	_
	tion:	27. Manner of Death  1 X Natural 5 Pending  28a. Date of Injury (Month, Day,Yea	/ at)	28b. Time of Inj	·   -	_ `	at Work?		ribe how	injury occurred			Ī
0 4 5 8 5	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Inju	ry - At hom	ne, farm, street,	factory, offi	ce buile	ding, etc.		ion (Strewn, State		r Rural	Route Number, City	_
the Hos hin 24 h the Fuo	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examinant manner stated,										ause(s)	
To witi	Me	29b. Signature and title of certifier			29c. Lic				29	9d. Date signed	(Month	. Day, Year)	_
		+ M. It	_		0.	C.M.	E		J	uly 8, 2009			
0		<ol> <li>Name and address of person/who completed cause of dea Jack Titus MD. Deputy Chief Medical Exc</li> </ol>		3a) 111 Penn	Street, E	Baltim	nore, MD	21201					
St Regis		31. Date filed (Month, Day, Year) 32. Registrar's	Signature	back			-	_					_

**Physician** /Medical Examiner

Examine

by Physician/Medical

Completed

Be ပ

Certification:

29b. Signature

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

**Funeral** 

Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

The law requires that the death certificate be executed and -trar physician and the burial-tr as attending I signed by the a d be detached f has certificate After Hospital or Attending in 24 hours after where the Funeral Director: Af

Division or Vital Records, P.O. Box 68760,

Part II. Other significant conditions	contributing to death but not re		23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ Yeo 3 ☐ Probably 4 ☐ Unknown								
				24a. Was an autopsy performed? 1☐ Yes 2√ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No						
25. Was case referred to medical		26. Place of Death (Check only one)									
examiner? 1 □ Yes 2 □ No	Hospital: 1 ☐ Inpatient 2[	☐ER/Outpatient 3☐ D0	ome 5 Residence 6	Assisted Living							
27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28d. Describe how injury	voccurred							
3 ☐ Suicide 6 ☐ Could not t 4 ☐ Homicide determined		home, farm, street, factor	28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	hysician: To the best of my ki				and manner as stated. place, and due to the cause(s)						

29c. License number

D30035

29d. Date signed (Month, Day, Year)

06/30/2009

State Registrar

1533 Memorial Drive Oakland, MD 21550 m.D. Donald R. Richter, 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature JUL 02

and manner stated.

within 24

Maria

# State of Maryland / Department of Health and Mental Hygiene

Bergstrom

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

4b. City, Town, or Location of Death

2. Date of Death

28,

June

2009

4c. County of Death

16:02

Phy:	sician
/Me	edical
Exa	miner

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy Injury or other traumatic event, the Modical Exeminer must be notified at once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

To the Hospital or Attending Physiclan: The law requires that the death certificate be executed attending physician and for use as the burial-trans

Division of Vital Records, P.O. Box 68760,

	Garrett Co. Memo	orial Ho	spital		0akl	and				Garre	tt	
	5. Social Security Number 6. Sex		(In yrs. last birthda		Inder 1 Year		24 Hrs.	8. Date of Birtl	h Vasa	9. Bir	thplace (State or Foreign ountry)	
	453-74-3811 1 <sup>1</sup>	]M 2[X]F	79 Yrs	. Moi	nths Days	Hours	Min.	8. Date of Birtl (Month, Day 8/30/	1 Q	29 6	ermany	
	Usual Residence of Decedent							0,00,			<u> </u>	
	10a. State 10b. County		10c. City, Town or	Location	1						10d. Inside City Limits	
_	1331 3131											
22	Wv Grant		Mt. S	Stor	r m						1 □Yes 21X No	
ē	10e. Street and Number			10	f. Zip Code	_			10g. Ci	tizen of What Co	ountry?	
runeral Directo	HC 76 Box 432				267	739			TT	.S.A.		
i a												
Ĭ	11. Marital Status	<ol><li>Was Decedent Ev Armed Forces?</li></ol>	er in U.S.	<ol><li>Was D If Yes.</li></ol>	ecedent of Hi specify Cuba	ispanic Or n. Mexicar	igin? (Sper 1. Puerto F	cify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit		
	1 Never Married 2 Married	1 ☐ Yes 2 X No If Yes, Give	·		es 212 No	Specify:					-,	
5	3 X Widowed 4 □ Divorced	Year or Dates:		1	ZA INO	зреспу.				Specify:	White	
npietea by	15. Decedent's Educ	cation	16a. De	cedent's	Usual Occupa	ation			16b. K	Kind of Business	/Industry	
<u>ē</u>	15. Decedent's Educ (Specify only highest grade	e completed)	(G	ive kind o	of work done of OT use retired	luring mos	t of workin	g			•	
Ë	Elementary/Secondary (0-12)	College (1-4or 5+)	1							TT		
3	12			HOME	emaker					Home		
ě	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name	(First, Middle,	Maider	n Surname)		
0	Andres	Mo	nter			Maı	cia			_	Frank	
-	19a. Informant's Name/Relationship (Ty)			ailing Ade	trace (Stract :			I Pouto Numbo	or City	or Town, State,		
	, .		- 1		,						•	
	Thomas Bergstro	m/ Son								WV 267		
	20a. Method of Disposition		20b. Place of Dis	sposition remators	(Name of or other place	e)	Da	ate	20c. L	ocation - City or	Town, State	
	1 ☐ Burial 2 ☒ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State				i i	- /20	/00	Das		110 DX	
			Countr	y S I C	ie cre	ill • i C	3/30,	/09	Dа	VIUSVI.	lle, PA	
	21. Signature of Funeral Service License	ee /	1	ZZ, Nan	ne and Addres	s or raciii	yNewi	man Fu	ine:	ral Ho	mes P.A.	
	Kicken I M	allered /	/1.	203	S. Se	cond	d St	., Oak	:la:	nd, MD	21550	
	23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that weed	e death. Do not	enter the	mode of dyin	g, such as	cardiac or	r respiratory ar	rest,		Approximate	
	shock, or heart failure. List only on immediate Cause (Final	ie caus									Interval Between Onset and Death	
	disease or condition	CORDI	YARY	A	OTER,	× 1	1156	A-5K			4YRS	
П	resulting in death)	Due to (or as a	consequence of):								, , , ,	
	tes sawas we	1)/	ARST	35	ms	11	in.	A5K		6400		
<u>u</u>	Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of):		1110		000				0112	
	cause. Enter Underlying	11	m								SYRS	
9	that initiated events cresulting in death) Last	Due to (or so o	/ Y								6 7 7 3	
Ù	toodiang in dodain, Labi	Due to (or as a	consequence of):									
2	d	!. <u></u>										
ysiciali/inedical												
ξ	IF FEMALE:	3c. If yes, outcome of	pregnancy							23d. Date of de	livory	
<u> </u>	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2	Fetal death		pic pregnancy					Month Month	Day Year	
2	1 ☐ Yes 2 🕱 No	4 ☐ Pregnant at ti 9 ☐ Unknown	ime of death	5 LI Othe	er (specify)							
	9 🗆 Unknown											
_	Part II. Other significant conditions con	tributing to death but	not resulting in the	e underly	ing cause give	en in Part I		23e. Did to	bacco	use contribute to	the cause of death?	
3	GARD							1 🗆 Y	es 2	! □ No 3 □ P	robably 4 Tunknown	
١												
5.	OSTEO ARTE	+RIDS						24a. Was a autop		24b. Were a	utopsy findings available completion of cause of	
complete								perfor	med?	death?	s 2 □ No	
ָרֵי בי	25. Was case referred to medical					00 Dise	of Do-Ab	1 ☐ Yes	-	5 1 1 Tes	5 2 1110	
ŏ	examiner?	lospital:			Othe							
2	TITIES ZAUNO	1 🖄 inpatient	t 2 ER/Outpa		_ DOA	4 🗆 N				6 ☐ Other (Spe	ecify)	
5	27. Manner of Death  1    Natural 5 □ Pending	28a. Date of Injury (Month, Day,	Year) 28b. Time	e of Ty	28c. Injury Work	y at ?	2	8d. Describe h	ow inju	ry occurred		
IIICation	2 Accident investigation		_ ′   _ ′	M		Yes 2 🗆	No					
ا اِ	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc.	y - At home, farm,	street, fa	ctory, office		2	8f. Location (S	treet a	nd Number or R	ural Route Number,	
	4 Homicide determined	building, etc.	(Specify)					City or Tow	n, Stat	e)		
	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
פ	29a. Certifier 1 Certifying Phys	sician: To the best of ner: On the basis of e	my knowledge, de examination and/o	eath occu r investic	urred at the tin lation, in my o	ne, date ai pinion, des	nd place, a ath occurre	and due to the	cause(:	s) and manner and due	s stated.	
בחבש	one)	and manner state			and the state of	p.1110-1, QC	au occurre	a actio iino, i	acro al		5 10 110 00000(0)	
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)												
	Can17	1 0			WV	19	761		1	6-71	-80	
ļ	COSKemls	ul mo			000	1 1/	0/			0 30	-07	
-	30. Name and address of person who co	mpleted cause of dea	ath (Item 23a) (Typ	e, Print)								
)	ALLANB. KU	1V/661	in D	OX	77	mo	7.5%	no Run	. L	UU 7	6720	
_	, , , , , , , , , , , , , , , , , , , ,	11111111111	1111	- /1			-	V /	1	-	-/-	

State Registrar

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760,

P.O. I

Records,

of Vital

Division

Completed Be Certification: To

1 X Natural

2 Accident

3 ☐ Suicide

29a. Certifier

Medical

4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending abused and

State Registrar

25. Was case referred to medical 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death

28a. Date of Injury (Month, Day, Year) 5 Pending investigation

6 ☐ Could not be determined

Other:  $4 \square$  Nursing Home  $5 \square$  Residence  $6 \square$ Other (Specify)  $\bigcirc$ HOSPICE 28b. Time of 28c. Injury at Work?

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

24a. Was an autopsy performed?
Yes 2 No

1 □ Yes

26. Place of Death (Check only one)

f 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier · Koucetcheu, 29c. License number D63748 29d. Date signed (Month, Day, Year) JUNE 26 2009

24b. Were autopsy findings available prior to completion of cause of death?

2 🗆 No

1 🗆 Yes

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOCELYN KOUATCHOU M.D. 6001 MUNCASTER MILL RD ROCKVILLE, MD. 20855

31. Date filed (Month, Day, Year, JUL 0 1 2009 32. Registrar's Signati

### State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2009 Jun Victoria Benson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner If Under 1 Year | If Under 244 5. Social Security Number Sex Age (In yrs. last birthday) **Funeral** Date of Birth (Month, Day, 1 □ M 2 🔀 F Months Days Hours Min Director 77 October 19, 1931 161-24-1835 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location other traumatic event, the Medical Examinar must be notified at Director PA Philadelphia Philadelphia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 221 East Hortter 19119 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ▼ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No Completed by Specify Specify 3 ₩ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Frank Sheppard, Sr. Lucy Lee Grant 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7207 Glenridge Drive, Hyattsville, Maryland 20784 Veronica Benson - Daughter Department of Healt Important: If Item 2: any Injury or other: once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ■ Burial 2 □ Cremation 3 ■ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lawn Cemetery 07/01/2009 Sharon Hill, Pennsylvania 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the dil as shock, or best filter. ase, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest Immediate Cause (Final theros eleratio **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to intravelate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 3 Ectopic pregnancy 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed Be 25.

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, Director: After this cerum. e Funeral I

					1 ☐ Yes 2 [	□ No 3 □ Probably 4 ☑ Unknown
<del></del>					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □Yes 2 □No
25. Was case referre	ed to medical	<del></del>		26. Place of De	eath (Check only one)	
examiner?	lo	Hospital: 1 ☐ Inpatient 2 ☑	ER/Outpatient 3 ☐ I	OOA Other: 4 Nursing	Home 5 ☐ Residence 6	G ☐ Other (Specify)
27. Major of Death 1 □ Natural 2 □ Accident	5 ☐ Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury	y occurred
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, street, factory)	ory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
		ysician: To the best of my knowning: On the basis of examina				and manner as stated. place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State

Certification: To

Medical

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day,

29d. Date signed (Month, Day, Year)

Month

Day

Year

のフスマ

Rupe

10d. Inside City Limits

**Black** 

Approximate Interval Between Onset and Death

Domestic

1 XYes 2 No

Birthplace (State or Foreign Country)

Pennsylvania

within 2 To the I

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . <sup>Day</sup>2009 June 25, 20:10PMM Burton Jeremiah Antwain 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Prince George's Clinton Southern Maryland Hospital 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days 1 **∑** M 2 □ F Months Hours Min 217-83-2786 13 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 □ Yes 2 □ X 10 Upper Marlboro Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20772 13300 Van Brady Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🐧 No 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Never Married 2 ☐ Married 1 □Yes 2 No African Specify If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced American 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) N/A N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Savoy Chantia Burton Larry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13300 Van Brady Road Upper Marlboro, MD 20772 Chantia Savoy (Mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) Dialy 2, 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Clinton, Maryland Resurrection Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Signature of Funeral revice L 6633 Old Alexandria Ferry Road Clinton, MD 20735 23a. Part 1. Enter the disease, or comshock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death)

**Physician** /Medical Examiner

attending physician for use as the burial

signed by the a

been si should !

cate has page 2 s

this certificate

nours after death.

neral Director: After this
filled in by the funeral d

within 24 hours after To the Funeral Direc

ð

Completed

Be

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Certification:

Medical

executed and burial-tran

The law requires that the death certificate be

Physician:

To the Hospital or Attending

Box 68760,

P.0.

of Vital Records,

Division

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

show

Director

Funeral

\$

Completed

Be

2

27 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "Notical Examiner must be notified at

Baltimore, Maryland 21215-0036

. Pages 1 and 2 should be file iment of Health and Mental Hismt: If item 27 Is marked oth

permit. Pages Department of Important: If it any injury or o

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical

w	/// OOSS OIL NIEMANGILL TOTTY HOLD	
plicat	ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line.	
a	Acute Aspiration	
b	Due to (or as a consequence of):  Chrimossmul Disorder	
	Due to (or as a consequence of):	
C	Due to (or as a consequence of):	
d		L

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No

9 Unknown

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Year

significant conditions contributing to death but not resulting in the underlying cause given in Part I. Shun

EG

24a. Was an autopsy perform

1 Yes 2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death? 2 **2** No 2 🗆 No 1 □ Yes 26. Place of Death (Check only one)

25. Was case referred to medical examiner? 2 No 1 ☐ Yes

Hospital: 1 Inpatient 28a. Date of Injury (Month, Day, Year)

≥ ER/Outpatient 3 □ DOA 28b. Time of 1 Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

27. Manner of Death 1X Natural 2 Accident 3 Suicide 4 ☐ Homicide

5 Pending investigation 6 ☐ Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifie

2 🗆 No

29d. Date signed (Month, Day, Year) 06/25/10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO V 29 2009 31. Date filed (Month) 32. Registrar's Signature Back

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 20<u>09</u> June 23. Merle Bodycomb 4:30 P 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 3936 W. Shore Drive Edgewater Anne Arundel If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9/28/1939 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
 Country) Days 1 □ M 2 🛛 F 69 Months 466-58-9221 Tennessee Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3936 W. Shore Dr. 21037 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 ☐ Yes 2X☐ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) years Autocad Operator Electrical Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Douglas Gemmell Ann Elizabeth Edmondson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter C. Bodycomb, III/Husband 3936 W. Shore Dr., Edgewater, Maryland 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Lakemont Cemeterv 6/27/09 4 ☐ Donation 5 ☐ Other (Specify) Davidsonville, MD 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Fundral Sorvice Licensee 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Breast TETESTATIC disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if an leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

show

death with the

within 72 hours after

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, It was

Baltimore, Maryland 21215-0036

Director

Funeral

⋧

Completed

Be

2

ed other than "natural", or items 23a or 28a-f shorevent, the Medical Exeminar must be notified at

Examine and burial-tran attending physician Physician/Medical as the l the þ signed be det ş Completed has been page 2 certificate director, Be မ Certification:

the death certificate be executed Hospital or Attending Physician; After 1 n 24 hours after death.

In Funeral Director: A pletely filled in by the fu death. completely the

Division of Vital Records, P.O. Box 68760

Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John H. Fetting, M.D.

9 Unknown

25. Was case referred to medical examiner?

5 Pending

investigation

6 Could not be determined

1 ☐ Yes 2 🗷 No

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

29c. License number

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

23e. Did tobacco use contribute to the cause of death?

24a. Was an

1 ☐ Yes

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

autopsy performed

2 A No

28d. Describe how injury occurred

1 ☐ Yes 2 INo 3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

00018-320

6125109

21093

28f. Location (Street and Number or Rural Route Number, City or Town, State)

9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. Date of Injury (Month, Day, Year)

10753 Falls Rd., Lutherville, MD

31. Date filed (Month, Day, Year) **JUN 26** 

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2009 eai 27, June 7:30 P M DORA ESTELLE BRADSHAW /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Alice Byrd Tawes Nursing Home Crisfield Somerset 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 □ XF 93 215-44-5874 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10c. City. Town or Location or 28a-f show notified at 10a. State 10b. County 10d. inside City Limits 1 ¥ Yes 2 □ No Director Crisfield Maryland Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? pe o 21817 408 Myrtle Street U.S.A. ral", or items 23a Examiner must b Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced er than "natura the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Beautician Hairdressing 7 is marked other traumatic event, Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Noah T. Evans Maggie Dora Jones P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Son) 1001 Limestone Court - Salisbury, MD 21804 Jackson Coulbourne Bradshaw item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Sunnyridge Memorial Park 7/1/09 4 Donation 5 DOther (Specify) Crisfield, MD 21. Signature of Furna Service Lio, nsee
Robert H. Bradshaw, Jr. 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St.-Crisfield, MD 21817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MEIA STATIC **Physician** COLON CANCER resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician and the burial-transit The law requires that the death certificate be executed Exam Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 38 attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Por in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has e 2 certificate has irector, page 2 autopsy perform 2 No or Attending Physician: director. 25. Was case referred to medica Medical Certification: To Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Injury (Month, Day Year) 1 ☐ Yes 2 ☐ No 2 ☐ Accident within 24 hours after death.

To the Funeral Director: A completely filled in by the f 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 斌 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

D. VITAY KARUMBUNAHAW, 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

201

48098

HALL HIGHWAY,

28

CRISFIELD

09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 7-1-09/Amend#26.PerPhys.PCCcr Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Vear **Physician** Rosalie Craig June 23. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Prince George's Upper Marlboro
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 16707 Village Drive West Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🖾 F 71 Director 578-50-6338 02/24/1938 DCUsual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Extendible Intermist be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1x Yes 2 □ No Director Prince George's Temple Hills 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6107 Old Branch Avenue 20748 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: þ Specify: Black 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Child Care Provider Child Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Issac Bright Rosalie Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6107 Old Branch Ave., Temple Hills, MD 20748
ce of Disposition (Name of Date 20c. Location - City or Town, State Allen W. Craig, Jr./Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 06/29/09 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory : Beltsville, MD 22. Name and Address of Facility Strickland Funeral Services 21. Signature of Funeral Service Licen 6500 Allentown Rd., Camp Springs, MD 20748 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LITERINE CANCER /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter the conful g Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 menths?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 9 Linknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 No Hospital or Attending Physiclan: '24 hours after death. Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Other 6 Nother (Specify) Pauchter's 2 No Hospital: ပ 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manuar of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 016619 Lune 26, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4041 POWDERNIU RD. CALVERTON, MD. 20765 VERGARA - SOARES 31. Date filed (Month, Day.)

JUL 0 1 2009 State JUL 01 Registrar

DHMH 17 Rev 1/2001

3 Time of Death

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland		
Department of Health and Mental Hygiene,	Fı Di	
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show	un re	_^
any injury or other traumatic event, the Medical Examiner must be notified at	er	
once.	al or	

Maryland 21215-0036

**Physician** 

**Physician** /Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Jas After this within 24 hours after death

To the Funeral Director:
completely filled in by the

Division or Vital Records, P.O. Box 68760,

10:12 A M July Robert Lawrence Carmick 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Washington County Hospital Hagerstown
or 1 Year | If Under 24 Hrs.
Days | Hours | Min. Birthplace (State or Foreign Country) If Under 8. Date of Birth (Month, Day, Year) April 11, 19 5. Social Security Number 7. Age (In yrs. last birthday, 1**⊠**M 2□F 208-16**-**6866 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No MD Washington Director Hagerstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 163 Southern Oak Drive 21740 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 🔀 No Specify: Specify: White <u></u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Regional Manager Register/Computer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anthony Carmick Hattie Elizabeth Kasculski ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Catherine K. Carmick / Wife 163 Southern Oak Dr. Hagerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State  $\frac{1}{7}$ /2009 4 ☐ Donation 5 ☐ Other (Specify) St. Mary's Cemetery Wilkes Barre, PA 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licensee 305 N. Potomac St. Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 3 days Preumonia disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4□Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2,25No SAINAI Stunosis 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Finpatient 1 ☐ Yes 2 No ပို 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), Blvd 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar JUL 0 2 2009

DHMH 17 Rev 1/2001

3H-10

20c. Location - City or Town, State Clinton, Maryland Lee Funeral Home, Inc. MD20735 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year)

3. Time of Death

7:30AM M

9. Birthplace (State or Foreign

10d. inside City Limits

1 ☐ Yes 2 No

Wirginia

U.S.A.

Registrar DHMH 17 Rev 1/2001

State

within 2.

29b. Signatore and title of certifier

31. Date filed (Month, Day, Year)

**JUN 29** 

MO

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Reg. No.	S.m	C/		-

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Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any lolury or other traumatic event, Ita Medical Examinat must be rotified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

	1 - State Registrar Certificate of Death Reg. No. 2 UU 3 224U								
	1. Decedent's Name (First, Middle, Last)					. Date of Death 3. Time of Death			
n	Betty Louise DeWitt				M	onth !	Day Year γear	9 3 7 AM	
ıl		-	41. Oh. T.						
r	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	h					
	Garrett County Memorial H		0akland				Garrett		
		e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hours	Min. (M	ate of Birth Nonth, Day, Yea	ar) Co	hplace (State or Foreign untry)	
	218-48-9566   ¹□м²¤F   8	35 Yrs.	July 5		Ju	ne 20 1	924 Mar	yland	
	Usual Residence of Decedent								
	10a. State 10b. County	10c. City, Town or Loca	ation					10d. Inside City Limits	
ģ	MD Garrett	0akland						1 TYYes 2 ☐ No	
ည	10e. Street and Number		10f. Zip Code			10a.	Citizen of What Co	untry?	
Funeral Director			21550				nited Sta	•	
ā	1113 Mary Drive								
PE P	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S. 13. W	as Decedent of H Yes, specify Cuba	ispanic Origir ın, Mexican, F	n? (Specify Y Puerto Rican,	es or No- , etc.)	14. Race - Ame Black, White		
E	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅	No	□Yes 2 No	Specify:			Specify:		
<u>.</u>	3 Widowed 4 □ Divorced Year or Dates:			<i>Dp</i>			Wh	ite	
ĕ	15. Decedent's Education (Specify only highest grade completed)	16a. Decede	ent's Usual Occup	ation	of working	16b	. Kind of Business/	Industry	
쯢	Elementary/Secondary (0-12) College (1-4or 8	life. D	ind of work done o O NOT use retired	f)	n working				
Completed by	6	Homen	naker			(	)wn Home		
9	17. Father's Name (First, Middle, Last)			18. Mother's	s Name (First	t, Middle, Maid	fen Surname)		
o Be	Lonnie Henry Rodeheaver,	Sr.		Edit	h Pear	1 Peck			
_									
	19a. Informant's Name/Relationship (Type. Print)						ty or Town, State, Z	Zip Code)	
١,	Terry DeWitt, Son		Hutton I		Oaklan	d, MD 2	21550		
	20a. Method of Disposition	20b. Place of Disposi cemetery, crema	ition (Name of	e) '0.7	/09 <sup>Date</sup>	00 20c.	Location - City or	Town, State	
	1 Marial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Garrett Me		-1			akland, M	D	
	21. Signature of Funeral Service Licensee								
	21. Signature of Fulleral Service Licensee	22.	David A	Burd	ock Fu	neral I	Home, P.A	•	
_	Ratherine Sweetzer						, MD 2155		
	23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each li	the death. Do not ente	r the mode of dyin	g, such as ca	ardiac or resp	piratory arrest,		Approximate Interval Between	
	Immediate Cause (Final	L MAT						Onset and Death	
	disease or condition resulting in death)	a consequence of):					- 1 Q N -		
	Due to (or as	a consequence on.					Years		
_	Sequentially list conditions, bb.						7-007-5		
Examiner	cause. Enter Underlying	a consequence of):							
аш	Cause (Disease or injury that initiated events c.								
	resulting in death) Last Due to (or as	a consequence of):							
edical	d.								
<del>-</del>									
2	IF FEMALE: 23c. If yes, outcome	of pregnancy					23d Date of del	ivon	
ä	in the past 12 months?	2 Fetal death 3 🗌	Ectopic pregnanc	у			23d. Date of delivery  Month Day		
S	1 ☐ Yes 2 ▼No 4 ☐ Pregnant a 9 ☐ Unknown 9 ☐ Unknown	it time or death 5 🗆	Other (specify)				_		
Physicia				VI. D. T.					
	Part II. Other significant conditions contributing to death b	ut not resulting in the und	derlying cause give	en in Part I.	1/2	23e. Did tobacc		the cause of death?	
Completed by	Here Kend falene, He.	ent failene	albi	2 L Wi	Ahefy	1 ☐ Yes	2 <b>X</b> No 3 □ Pr	obably 4 Unknown	
	Dear 62 hura House	in Anon	5 66	FRO	2	24a. Was <i>a</i> n	24b. Were au	topsy findings available	
ᇤ	perfect the spector of the	1110	7,	77		autopsy	l prior to o	completion of cause of	
3	Anxiety				. 1	performed □Yes 2 🔀	No 1 ☐ Yes	2 No	
e D	25. Was case referred to medical examiner?				of Death (Che	eck only one)			
0		ent 2 ER/Outpatient	3 □ DOA Oth	er: 4 🗌 Nurs	sing Home 5	5 🗌 Residence	6 □Other (Spe	cify)	
=	27. Manner of Death 28a. Date of Inju	ry 28b. Time of Injury	28c. Injur Worl	y at	28d. D	Describe how in	njury occurred		
	1 Natural 5 □ Pending (Month, Da 2 □ Accident investigation	y, rear) Injury		Yes 2∐No	0				
2	a Classic Could not be	urv - At home, farm, stre	et, factory, office		28f. L.o	ocation (Street	and Number or Ru	ıral Route Number.	
Ę	4 Homicide determined building, et	ury - At home, farm, stree c. <i>(Specify)</i>	,,,		C	City or Town, St	tate)	Tal Fronto Harrioon,	
3	29a. Certifier								
g	(Check only 2 Medical Examiner: On the basis of	of my knowledge, death of examination and/or inv	occurred at the tire estigation, in my o	ne, date and pinion, death	place, and do noccurred at	lue to the caus the time, date	e(s) and manner as and place, and due	s stated. to the cause(s)	
Medical Certification:	one) and manner st	ated.				,	. ,		
≥	29b. Signature and title of contifier		29c. Licens	e number		29d.	Date signed (Monti		
	hehentike		TIOO	6/1705		1	7/7/2	2009	
	30. Name and address of person who completed cause of c	looth (Itam 33a) (Time 5		64705			/ ' /	•	
2		311 N. 4		t. Oak	land	MD 21	550		
ر	Richard A. Porter, DD		ru price	c, Vak		4.I			
,	31. Date filed (Month, Day, Year)  32. Registr	ar's Signature	Colles !						
r	JUIL " O GULLE	was of.	Chen						

State Registra

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State o	of Marylar	_	artment of F rtificate of		Mental Hy	(%)	000	221.07
			Registrar  1. Decedent's Name (First, Middle,	Last)		061	incate or		2. Date of De	Reg. No.	UUJ	3. Time of Death
	Physicia /Medic		HELEN EILEEN DOYLE JUNE								Year 2009	1:30P M
	Examin		4a. Facility Name (If not institution,				4b. City, Town, o		th		nty of Death	
, K			FREDERICK MEMO  5. Social Security Number	ORIAL HOS	7. Age (In yrs.	la ct hirthday)	FREDERIO	CK I If Under 24 Hr	s. 8. Date of Bir		DERICK	place (State or Foreign
	Funeral Director		218-12-5855	1 □ M 2 🖾 F	84		Months Days	Hours Min		, 1924	Mary	land
	2		Usual Residence of Decedent  10a, State 10b. County		10c Ci	ty, Town or Lo	cation				1	0d. Inside City Limits
	f shore	ō		and als	100. 01		erick				'	1X Yes 2 □ No
-	28a- notifi	Director	Maryland Frede  10e. Street and Number	FICK		rred	10f. Zip Code			10g. Citizen	of What Cour	ntry?
3	23a ol		502 Pearl Street				21701			Unite	d Stat	es
1	er mu	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13. \	Was Decedent of H	lispanic Origin? ( an, Mexican, Pue	Specify Yes or No	)- 14. F	Race - Americ	
2	", or II	by Fi	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 ∐ Yes If Yes, G Year or D	ive		1 □Yes 2 🖫 No	Specify:			cify: Whit	
5	atura		15. Decedent's	Education		16a. Deced	dent's Usual Occup	ation		16b. Kind o	f Business/In	dustry
7	nan "n	Completed	(Specify only highest Elementary/Secondary (0-12)	College (			kind of work done DO NOT use retired	,	orking			
7	Hygier Hygier her th		47 Sabada Nama (First Middle I	3		Regis	tered Nu		ame (First, Middle		h Care	
ב ב	penint. Tages a rain 2 should be lifed whitin 72 hours aren bean with the war yeard Department of Health and Montal Hydiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'm Machael Examiner must be notified at once.	To Be	17. Father's Name (First, Middle, L Frank Andrews	451)					arl Fral		iame)	
d .	and M s marl	ř	19a. Informant's Name/Relationshi	p (Type. Print)		19b. Mailir	ng Address (Street	and Number or F	Rural Route Numb	er, City or To	wn, State, Zij	Code)
¥ ;	ealth and 27 is		James B. Doyle /	' Husband			earl Str		derick,			
2	or oth		20a. Method of Disposition 1 □ Burial 2 🗷 Cremation	3 ☐ Removal from	State		sition (Name of natory or other plac	June	Pate 29,	20c. Location	on - City or To	own, State
	artmer artmer ortant injury		4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of #uneral Service L		Re		Cremato		2009			Maryland
ם פ	Deparation of the property of		Digitator of tariolal convicts				Name and Address thaven 1.01 Catoci					
			23a. Part 1. Enter the di x ase, or o shock, or heart fa ure. List o	or plications that	caused the deat	th. Do not ent	er the mode of dyin	ng, such as cardi	ac or respiratory a	ırrest,	sate ma	Approximate Interval Between
	hysician		Immediate Cause (Final disease or conditi resulting in death	La. Me	poer ten		Condio	Vers ca	les of	13ansl		Onset and Death
	/Medical xaminer		resulting in death	Dulyt	(or as a consec	quence of):						
-3		ner	Sequentially list conditions,	b. Due to	(or as a consec	juence of).						
24100	and	Examiner	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c								
ָהָבָּילָ מַלְינִי	physician and s the burial-transit	al E	resulting in death) Last	Due to	(or as a consec	juence or):						
100	g phys	edical	·	d								
5	attending for use as	M/us	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn		∃Ectopic pregnanc			23d.	Date of deliv	ery
	the att	Physician/M	in the past 10 months? 1 ☐ Yes 2 X No		gnant at time of		Other (specify)	· y			Month	Day Year
, toth	signed by the a		9 Unknown  Part II. Other significant condition	ns contributing to	death but not res	sulting in the ur	nderlying cause giv	en in Part I.	23e. Did	tobacco use c	ontribute to t	he cause of death?
Divisions The Jan requires that the death contilients to constitute	n sign	d by							1 🗆	Yes 2 N	o 3□ Pro	bably 4 🗌 Unknown
	has been s	Completed							24a. Was		b. Were auto	ppsy findings available
	his certificate ha	Com							· auto perfo 1 □ Yes	psy ormed? 2.21No	death?	mpletion of cause of
A ILC	sertific ector,	Be (	25. Was case referred to medical examiner?	Henrital: 9			0.1		eath (Check only	one)		
5	r this c	٦.	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1	Inpatient 2	ER/Outpatier 28b. Time of		4 LI Nursing	Home 5 ☐ Res			fy)
VISIOII Attending	th. : Afte e fune	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	(Moi	nth, Day, Year)	Injury	Wor	k? Yes 2 □ No	Eco. Bosciiso	now injury oo	surreu	
2 4	er dea rector by th	Certification:	3 Suicide 6 Could no 4 Homicide determin	and 28e. Place	e of Injury - At h	ome, farm, str fy)	eet, factory, office		28f. Location (	Street and Nu wn, State)	mber or Run	al Route Number,
O the Meenitel or	within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral		00 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Di Lia Tan								
Hoe	24 ho e Fune letely f	Medical	29a. Certifier (Check only one)  Certifying  Certifying  Medical E	xaminer: On the	e best of my kno basis of examina nner stated.	owledge, death ation and/or in	h occurred at the ti vestigation, in my o	me, date and pla opinion, death oc	ce, and due to the curred at the time	cause(s) and date and pla	manner as ce, and due t	stated. o the cause(s)
To th	within To the compl	Me	29b. Signature and title of certifier	an	1		29c. Licens	e number		29d. Date sig	ned (Month,	Day, Year)
			Xold L.	Karol	man	2,1	nD D	-/397	7/	4/	29/0	9
	6		30. Name and address of person w	ho completed cau	se of death (Ite				. 0	1	v -	h . N
	Sta	to	31. Date filed (Month, Day, Year)		reet Registrar's Sigh	trede	rick, M	2170	1 Kob	sertl.	Kautr	nann, MD
	Sid Renistr		HM 3 0 2	000 /2		9 100	Rad					

DHMH 17 Rev 1/2001

Abdul Doraney 09-04995 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ June 24, 2009 1145 hrs Medical Examiner c. County of Death 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Montgomery MacArthur Blvd Potomac 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Min Hours Months Director Country) TRAN 212-69-9260 10 1 X M 22 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 1 K Yes 2 No 23a or 28a-f show notified at once. oudour Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Funeral Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Numbe 01 am. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married Yes 2 X No specify: Give Yea Widowed Divorced Yes the Medical Examiner à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) If item 27 is marked other than Waiter 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) DORANEY Be traumatic event, (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ျှ 19b. Mailing Address FATHER 9429 DORANE 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 2 Cremation 3 Removal from State X Burial Comfort mount 09 mportant: Donation 5 Other Specify: Signature of Funeral Service Licensee 22. Name and Address of Facility Bell willip the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval 23a. Part I. Enter Physician Between Onset and failure. List only one cause on each line. /Medical Death a. Drowning Immediate Cause (Final disease caminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

25 hours after death.

• Funeral Director: After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical UNPENDED **AMENDED** Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month Live birth 3 Ectopic pregnancy Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? 2 No ✓ Yes 2 1 🗸 26.Place of Death (Check only one) of Vital 25. Was case referred to medical Be lospital: 1 Other; examiner? Inpatient ER/Outpatient 3 Nursing Home 5 Residence 6 ✔ Other: Scene 1 Yes No 28a. Date of Injury FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Subject drowned FOUND: Natural Yes 2 V No Pending Jun 24, 2009 1110 hrs 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) MacArthur Blvd, Potomac, MD

Division within 2

> Patricia Aronica-Pollak MD 31. Date filed (Month, Day JUL 0 1 200 32. Registrar's Signature

Homicide

29b Signature and title of certifier

29a. Certifier 1 (Check only one) 2

Medical

State Registrar

determined

Assistant Medical Examiner

(Specify) River

and manner stated

**ORIGINAL** 

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

June 25, 2009

DHMH 17 Rev 1/2001 OCME 2006

30. Name and address of person who completed cause of death (Item 23a)

State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2009 Jüne 26 4:35 A. M Donald Anthony Diggs /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Adelphi Heartland Health Care Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Day, Year, 03/18/1951 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Months Days Hours Min Wash., D.C. 1**%** M 2 □ F 578-66-2130 58 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, The "Indical Evandor Fusit Leventhal" and sonce. 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 TYYes 2 □ No Director Laurel Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20708 11654 South Laurel Drive # 1B U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√€ No Specify. Specify: Black ð 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chef Nursing Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles Diggs Louise Cox Jackson ၉ 19a. Informant's Name/Relationship (Type. Print)

Gwendolyn Brower/Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4970 Piney Ridge Church Rd., Seagrove, N.C. 27341 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 06/30/09 Beltsville, Md. Chesapeake Crematory, Inc. 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses Name and Address of Facility
H.S.Washington & Sons Co., Inc. 1204 4925 Burroughs Ave., N.E., Washington, D.C. 20019 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final evosclerofe Cardiovascular **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, led by the attending physician detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) 9 I Inknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Tes 2 No 3 Probably 4 Unknown page 2 should Completed been s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 2 No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2₺No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 X Natural death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0060100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 831 University Blvd. East, Silver Spring, Maryland 20903 Tahmina Ahmed, M.D.

DHMH 17 Rev 1/200

State Registrar

31. Date filed (Month, Day Ye JUL 0 1 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician 25,2009 June Vonne /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Jown, or Location of Death Examiner Anne Innapolis er 1 Year | If Under 24 Hrs. Hrunde (In yrs. last birthday) 45 Yrs. If Under 1 Year 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex Year) **Funeral** Months Days Hours Min 578-84-4190 JOV. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State or 28a-f show event, the Medical Examiner must be nutified at 1 √es 2 No Washington Director D 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 "natural", or Specify: Black Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) and Mental Hygiene. Is marked other than College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Albert De bose 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print, permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is n any Injury or other traun once. Nashington MD 20744 Fort 10805 offine 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7-2-09 nesopeake 4 Donation 5 Dother (Specify) 22. Name and Address of Facility PRIDGEN 21. Signature of Funeral Service License 9908 Hutchelloille HD 23a. Part 1. Enter the disease, or complications that call ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on earn line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1 mmode ficher Physician acquire /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Examiner Hospital or Attending Physiclan: The law requires that the death certificate be executed use as the burial-transi Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 □Yes 2 □ No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 2 No 1 ☐ Yes 1 ☐ Yes of Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No 1 🗖 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27 Manner of Death After Injury Division atural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death. the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined filled in by 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and little of certifi 29c. License number

State Registrar

DHMH 17 Rev 1/2001

Medical Parhwa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ate filed (Month, Day, Yes JUL 0 1 2009

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	Phy /M Exa	sici edi: mir
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and
	1	B

	_	For	Plea				l / Depa	artment of H	Ensure Allealth and M	-	_	jible.	
		State Registrar  1. Decedent's Name	e (First, Middi	e, Last)				rtificate of	Death	2. Date of Death	eg. No. 2	000	3. Time of Death
Physicia /Medica		019	ire	L	n	eet	ter	JK		June 23	T "		3:44 P M
Examine		4a. Facility Name (/ 12 Pafe1		n, give street a	and number)			4b. City, Town, o	r Location of Death			ity of Death e Arui	nde1
Funeral Director		5. Social Security N 208-14-2	umber	6. Sex		ge (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, 9/19/19	Year)	9. Birth Cou	place (State or Foreign
D		Usual Residence of					Town or Lo	cation		., ., .,			10d. Inside City Limits
permit. Fages I and 2 should be intelled within 72 hours arer death with the maryland bing attent death and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it. In clical Evar, incr. quet by notified a long.	to	Maryland	,	Arunde:	1	100. 01.9,		apolis					1 ☐ Yes 2 X No
or 28a	× 1	10e. Street and Nur	mber			1		10f. Zip Code		10	og. Citizen o		ntry?
s 23a	eral	12 Pafel	Rd.	12 \A/a	s Decedent	Ever in II S	13	214		ecify Ves or No-		SA ace - Ameri	ican Indian
or item		<ol> <li>Marital Status</li> <li>Never Marr</li> </ol>	ied 2 🔀 Mar	Arr	med Forces? Yes 2   es, Give	)		If Yes, specify Cuba 1 □Yes 2 🏋 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	Rican, etc.)	В	lack, White,	
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and Me s mark umati	ပ္	19a. Informant's N				,		ng Address (Street	and Number or Rui				ip Code)
m 27 is		Frances		ter/ W	ife				, Annapol			- O'	Otata
nt of H		20a. Method of Dis	Cremation		al from State			osition (Name of matory or other place			20c. Location		
ortme ortani injury		4 □ Donation  21. Signature				St.		's Cemete  2. Name and Addre		orge P.	Annap Kalas		
lmp any one		1/1/10	Me		antifes			2973 Solo	mons Isla				
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within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the total states.	Physician/Medica	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2   9 □ Unknown	months? □ No	1 [ 4 [	yes, outcome ☐ Live birth ☐ Pregnant ☐ Unknown	2 Fetal	death 3[	☐ Ectopic pregnand ☐ Other (specify) _	су			Date of deli	very Day Year
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icate has bee	Completed										ned?• No	b. Were aut prior to c death? 1 ☐ Yes	opsy findings available ompletion of cause of 2 DNo
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Vfter th	on: T	27. Manner of Dear	5 Pendi		a. Date of Inj (Month, D	ury a <i>y, Year)</i>	28b. Time o	Wor	ry at rk?	28d. Describe ho	-		
after death Director: / I in by the f	Certification:	2 Accident 3 □ Suicide 4 □ Homicide	invest 6		e. Place of In building, e	jury - At hor tc. (Specify	me, farm, st	M 1 C	]Yes 2□No	28f. Location (St City or Town		mber or Ru	ral Route Number,
n 24 hours ne Funeral	Medical C	29a. Certifier (Check only one)		Examiner: C		of examinat			ime, date and place opinion, death occu				
within	Š	29b. Signature and	title of certific	John	n			29c. Licen:	se number 4768	2	9d. Date sig	ined (Month	n, Day, Year)
B		30. Name and add	lian	1	Dak	165	J	r 2-	17 Per	insulc	i Fa	rmk	d Arnold
Stat Registra		31. Date filed (Mor	JUN 25		32. Negis	trar's Signati	d.	an					

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Melvin G. Fazenbaker	State of Maryland / Department of Health and Mental Hygiene

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		- 1	- For State Registrar		Certifi	icate of	Death		1	Reg. No.	. U U	
	Physicia I Exami	an/	1. Decedent's Name (First, Middle Melvin Glenn	e,Last) n Fazenbake	rJR				2. Date of De Month July 1, 20	Day Y	еаг	3. Time of Death 1407 hrs
			4a. Facility Name (if not institution 19208 Legislative Roa			41	Barton	ocation of D	Death	4c. Count Allega	y of Death	
	Funeral Director		5. Social Security Number 217–74–8375	6. Sex 7. Ag	e (In yrs. last t	birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours		5/1956	YY) 9. Birt Foreig Co	thplace (State or in Maryland untry)
2	ith the Maryland 23a or 28a-f show any notified at once.	Director	Usual Residence of Decedent		10c. City, Too Bar		10f. Zip Code			10g. Citizen of		
`	with the N ns 23a or		19208 Legisla	12. Was Decedent					? ( Specify Yes or N		ice - Ameri	tes ican Indian, Black,
	after death	by Funeral		orced or Dates:	_ № 974	1	s, specify Cuban, Yes 2 X No	specify:		Specif		
36	Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiers and the fired and and an arthed of ther than "natural", or items 23a or 28a-fahr uit. If item 27 is marked of ther than "natural", or items 23a or 28a-fahr rother traumatic event, the Medical Examiner must be notified at once	Completed I	15. Decedent's Education (Spec Elementary/Secondary (0-12) 12	cify only highest grade cor College (1-4 or	<u> </u>	during mo	's Usual Occupationst of working life. In the control of the contr			16b. Kind of Shee	Business/let Me	
215-0036	should be filed wit and Mental Hygien 7 is marked other natic event, the M	Be	17. Father's Name (First, Middle, Melvin Fa		R			Phy	Name (First, Middle	zenbakeı	5	
MD 21	d 2 should Ith and Me n 27 is ma numatic ev	2	19a. Informant's Name/Relations Gail Fazenbake			267 Na	tional H	Iighwa		, LaVale	e Mar	yland 21502
Baltimore,	permit Pages I and 2 s Department of Health a Important: If item 27 injury or other traum:		20a. Method of Disposition  1 X Burial 2 Cremation  4 Donation 5 Other Sp				tion (Name of cem er place) .1 Cemete		07/07/ 2009	Barto	on, M	aryland
Balti	permit Departn Import injury		21. Signature of Funeral Service	Licensee		11		st.,	Boal Fur Western	port, Ma	ryla	
/	ysician Medical aminer		23a. Part I. Enter the disease, or failure. List only one cause immediate Cause (Final disease	on each line. a. Anaphylac	tic rea			such as car	diac or respiratory a	arrest, shock, or	heart	Approximate Interval Between Onset and Death
		Examiner	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Probable  Due to (or as a cons  c.  Due to (or as a cons	bee st equence of):	ing						
•	ficate be executed g physician and s the burial - transit	n/Medical E	X UNPENDED	X8/5/09 TI	as not	ed per	ME , PI	line	a-b, PI	1,27,28	a-f,p	erME, g894
Division of Vital Records, P.O. Box 68760,	s that the death certificate b gned by the attending physi e detached for use as the bu	/sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unit	23c. If yes, outco	me of pregnar	2 Fet	al death 3 [ ner (Specify)	Ectopic p	pregnancy	23d. Date Monti	e of deliver	y Day Year
P.O. E	ires that the c signed by th I be detached	by Phys	Part II. Other significant condit			•						the cause of death?
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<u> </u>	ysician: The l his certificate l director, page	Bec	25. Was case referred to medica examiner?	Hospital:				Other	Check only one)			
Š	Physicar this eral dir	ျ	1 Yes 2 No 27. Manner of Death	1 Inpati		R/Outpatient 8b. Time of Ir		y at Work?	Nursing Home 5	Residence		er: Scene
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Division	To the Hospital or Attending Phywithin 24 hours after death.  To the Funeral Director: After to completely filled in by the funeral	Certification:	3 Suicide 6 Coul		njury - At hom	e, farm, stree	et, factory, office b	ullding, etc.	28f. Locatio or Town Barto	, State) 192	mber or R 08 Le	ural Route Number, City gislative R
	o the Hosp ithin 24 ho o the Fune ompletely fi	Medical C	29a. Certifier 1 ☐ Certifying P one) 2 ✓ Medical Exa	hysician: To the best of raminer:On the basis of example and manner stated	amination and	death occur or investigat	red at the time, da	te and plac	e, and due to the courred at the time, da	ause(s) and mar ate and place, ar	nner as sta	ited.
	<b>-</b> » <b>-</b> ŏ	Me	29b. Signature and title of certifie		A	_	29c. License O.C.I			29d. Date s		onth, Day, Year)
			30. Name and address of personal Jack Titus MD. Dep	h completed cause of buty Chief Medical E			nn Street, Balt	imore, M	1D 21201		_	
	S Regis	tate	31. Date filed (Monty Pay, Year)	2000 32. Registr	ar's Signature	8. Be	willed					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) June 28, 2009 6:00 NINA VIRGINIA FOREMAN AM 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 20061 Dogstreet Road **Keedysville** Washington 8. Date of Birth (Month, Day )
July 17, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Year) 921 Days Hours 1 □ M 2 👿 F Virginia 217-18-7903 87 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ▼ No Maryland Washington Keedysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20061 Dogstreet Road 21756 U.S.A. . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No Specify: Specify: White 3₺ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Leather Worker Bucheimer Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Chester Harrison Stone May Elizabeth Stallings 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20061 Dogstreet Road, Keedysville, MD 21756 Georgeanna M. Crim / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Resthaven Mem. Gardens 7/1/09 Frederick, Maryland 22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 21. Signature of Fureral Service Licens 1201 NORTH MARKET STREET, FREDERICK, MD 21701 ase, or complications that aused ailure. List only one cause the ach lin death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter it as ase, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Due to (or as a conseque ce of) Due to (or as a one quence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify)

**Physician** /Medical Examiner

permit. Pages 1 and 2 should be file.

Department of Health and Mental Hy important: If item Z7 is marked othe any Injury or other them.

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

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items 23a

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Injury or other traumatic event, the Medical Examiner must be notified at

Completed by Funeral Director

Be

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records, P.O.

or Attending Physician: The law requires that the death certificate be executed the attending physician and ned for use as the burial-transit After this certificate has ours after death.

neral Director: A To the Hospital o within 24 hours af To the Funeral Di

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Physician/Medical Examiner IF FEMALE: 23b. Was decedent pregnant in the past \$2 months? 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 🗌 Yes 24a. Was an autopsy performed 1 ☐ Yes 2 ANo 25. Was case referred to medical 26. Place of Death (Check only one) 1☐ Yes 2No Other: 4 Nursing Home 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signatur 29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes

2 **X**No

2 **X** No

se of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

3

State Registrar

KB

# permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ihu Mudical Examinar must be notified at once. Baltimore, Maryland 21215-0036

31. Date filed (Month, Day, Year)

Be Completed by Funeral Director

2

Examiner

Medical Certification: To Be Completed by Physician/Medical

Physician

/Medical

**Examiner** 

Funeral

Director

Physician /Medical Examiner within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

State Registrar					artment of h rtificate of				Reg. No.	0 -	
1. Decedent's Name	e (First, Middle, La	st)					2.	Date of De	eath	200	3. Time of Death
Amy	1	Elizabeth			Frank1	lin	Jī	Month une	27 <b>,</b> 2	2009 Year	9:12 A <sup>M</sup>
1727 Do	gwood Dr:	ve street and number, ive	)		Freder				4c.	County of Dea Freder	
5. Social Security N 021-54-8	399	Sex 7. Ao 1 □ M 2√ F	ge (In yrs. last b 46	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	i	Date of Bi (Month, Di 18. 18	ay, Year)	C	rthplace (State or Foreign ountry) sachusetts
Usual Residence of 10a. State	f Decedent 10b. County		10c. City, Tov	wn or Lo	cation						10d. Inside City Limits
Maryland	Frederio	ck	Fre	der	ick						1 X Yes 2 □ No
10e. Street and Nur	mber Wood Driv	7e			10f. Zip Code	21701			10g. Citi:	zen of What C	ountry?
11. Marital Status		12. Was Decedent		13.	Was Decedent of H		Specif	y Yes or No	D- 1	14. Race - Am	
	ied 2□ Married 4 🛱 Divorced	Armed Forces? 1	?		If Yes, specify Cub 1 □ Yes 2 🖾 No		rto Ric	an, etc.)		Black, White	
(Spec	15. Decedent's Ecify only highest gra	ducation ade completed)	16	(Give	dent's Usual Occup kind of work done	during most of wa	orkina	- 8	16b. Kir	nd of Business	/Industry
Elementary/Seco		College (1-4or	5+)	life.	DO NOT use retire	d)	9				
17. Father's Name					Sales	18. Mother's Na	me (F	irst, Middle	, Maiden	<u>Reta:</u> Surname)	11
Isaiah		ndrew	S	teir	ı			rite		Wood	
19a. Informant's Na	ame/Relationship (	(Type. Print)	19	b. Mailir	ng Address (Street				_		Zip Code)
Margueri	te Isman/	Mother		1727	Dogwood	Drive.	Fre	deric	k.MD	21701	
20a. Method of Disp 1 ☐ Burial 2	position	Removal from State	20b. Place cemet	of Dispo ery, crei	sition (Name of matory or other place Cremato	ce)	Date	9	20c. Lo	cation - City or	
21. Signature of Fu	uneral Service Lice			22	2. Name and Addre	ess of Facility $St$					
	) 1	× × × × × × × × × × × × × × × × × × ×				sumtown		e, Fr	eder	ick,MD	21702
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Registrar

6

State

KB

DHMH 17 Rev 1/2001

State Registrar

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JUL 0 1 2009

Rajkumar G. Bhojraj, 704 Gorman Avenue, #T1, Laure1, MD 20707

32. Registrar's Signature

29c. License number D23181

29d. Date signed (Month, Day, Year)

6/30/2009

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** ORIS 01:08A 2009 6 4 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Annapolis Anne Arundel Ginger Cove If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 2/27/1918 5. Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Country) Months 1□M 2/20 F 135-03-6582 91 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Evandener must be notified at 1 ☐ Yes 2 No MD Anne Arundel Annapolis Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number or items 23a or 21401 USA 4000 River Crescent DR. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ∐Yes 2½∏ANo If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married White 1 ☐ Yes 2√XNo Specify: Specify. ģ 3x DtWidowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, Importe. Once. Elementary/Secondary (0-12) College (1-4or 5+) Oil Painting/ Ceramics Artist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mabel Wakefield Edward Ade ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Houston, TX 77080 2630 Rosefield Dr. Barbara Faber Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Restland Memorial 6/29/2009 East Hanover, NJ permit. 21. Signature of Fundral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 1/20 Annapolis, MD 21401 12 Ridgely Ave. Approximate Interval Between Onset and Death 23a. Part 1. Enter the diseased or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner car Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No Pregnant at time of death 5 ☐ Other (specify) 9 Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has be irector, page 2 s autopsy 2 No 1 ☐ Yes 2 No 1 ☐ Yes this certifical Be 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) GINGER Hospital: Other: 4 Nursing Home 5 Residence 6 Other Spe 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To CJVE 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending investigation s after death. I Director: After in by the further. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760, within 24 hours aft

To the Funeral Di

completely filled in the

Baltimore, Maryland 21215-0036

	**			
29a. Certifier (Check only one)	2 Medical Examiner: O		ledge, death occurred at the time, date and place, on and/or investigation, in my opinion, death occurred.	and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)
29b. Signature and	d title of certifier	PA	29c. License number	29d. Date signed (Month, Day, Year)

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776 HWY

FUNAPOUSMD ZIYUI

State Registrar

Medical

31. Date filed (Month, Day, Year)

32. Registrar's Signature

NM

Name and address of person who completed cause of death (Item 23a) (Type, Print

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1 - For State Registrar 1. Decedent's

Marylan 10e. Street an 354 L

Director

Completed by Funeral

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Examiner

Physician/Medical

Completed by

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Medical Certification: To

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suresh Share Lige, M.D., VA Mary br

31. Date filed (Month, Day, Year)

32. Registrar's Signature

JUL 01 2009

Junua B. Jan

Physician

/Medical

Examiner

**Funeral** 

Director

For State	JIAIE OF	Maryland /	•	icate of		ara iviel		0.0	100 0	01.1
Registrar  Decedent's Name (First, Middle, Last)			Jei IIII	Jaic UI	Juan	2	Date of Death	. No. /	3. Tim	ne of Death
	lliam (	Goolshy				-	Month	Day 21	Year 7:3	JP M
Facility Name (If not institution, give s			4b	. City, Town, o	r Location of	f Death		4c. County	of Death	, ,
AmarulandHe	althCo	ure Suste	mf	Perru	Poir	it		Cec		
Social Security Number 6. Sex 243-28-3412	M 2□F	7. Age (In 975. last b	m triudy)	Under 1 Year onths Days	If Under 2 Hours	Min.	Date of Birth (Month, Day,		9. Birthplace (St. Country) North (	<sub>ate or Foreign</sub> Carolin
ual Residence of Decedent										
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ryland Harford	i		14	Edgew Of. Zip Code	ood		100	n Citizen of V	What Country?	-74(,,,,
e. Street and Number 354 Laburnum Road	l		1		1040		10	12	U.S.A.	
	12. Was Deced	lent Ever in U.S.	13. Was	Decedent of H		gin? (Specif	y Yes or No-	14. Rac	e - American India	n,
1 Never Married 2 Married	Armed Ford	2 □ No	40	s, specify Cuba Yes 2 <b>K</b> No		Puerto Ric	can, etc.)		ck, White, etc.	
3 Widowed 4 Divorced	If Yes, Give Year or Dat	tes: 1945-46	,   10,	res ZALINO	Specify:			Specify	" Black	
15. Decedent's Educ (Specify only highest grade	cation e completed)	16	a. Decedent (Give kind	's Usual Occup I of work done VOT use retired	oation during most	of working	10	6b. Kind of Bu	usiness/Industry	
Elementary/Secondary (0-12)	College (1-4			vor use retired Dishwas				[11	nknown	
Father's Name (First, Middle, Last)	ulikilowi	ı	L	JISHWaS		r's Name <i>(F</i>	First, Middle, Ma			
John Goo	olsby					Ві	irdie B	ergerl	uke	
a. Informant's Name/Relationship ( <i>Ty</i> )	pe. Print)						Route Number,		State, Zip Code) d 20716	
a. Method of Disposition	,,	20b. Place	of Disposition	n (Name of		Date			City or Town, Stat	te
1 N Burial 2 □ Cremation 3 □ R	lemoval from St	cemet	tory promata	* 44 2						
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29d. Date signed (Month, Day, Year)

Nearth Care System, Perry Point, MD

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

VO

State

Registrar

park

29c. License number

09-04930

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Ziyonna Selah Go		win-Carr S	tate of Maryla		artment of tificate of		and M	iental Hy		- Na	0.0	00 001 1
Physicia		Registrar 1. Decedent's Name (First, Midd	ile,Last)						2. Date of Deat		<del>- U</del>	3. Time of Death
Medical Examin	_	ZIYONNA SEL		DWIN-CAR	RR				June 22, 2		ļ	0830 hrs
ű		4a. Facility Name (if not institution Prince George's Hos	on, give street and nu			4b. City, Town		tion of Death		4c. County Prince (		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1		Under 24Hrs.	8. Date of Bir	th (MM/DD/YYY	() 9. Birt	thplace (State or InMARY LAND
Director		219-83-3826	1 M 2 XF		Yrs		Days F	Hours Min.	FEB. 8			untry)
	ŀ	Usual Residence of Decedent	1 N 2 21			4			TED.	2007	<u> </u>	
any	ı	10a. State 10b. County	,	10c. City,	Town or Locat	ion						10d. Inside City Limits
show	5	MD PRIN	CE GEROGE	S	CHEVERI	LY						1 XYes 2 No
Maryl 28a-f	Director	10e. Street and Number				10f. Zip Coo				0g. Citizen of W	hat Cour	ıtry?
A the Oatifie		911 CYPRESSTR				20743				JSA		Disab.
reath with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral	11. Marital Status  1 X Never Married 2		cedent Ever in U orces?	.s. 13. Wa	as Decedent o 'es, specify C	if Hispanii uban, <b>Me</b>	ic Origin? ( Spexican, Puerto I	ecify Yes or No Rican, etc.)		e - Ameri te, etc.	ican Indian, Black,
er dea	ᆵ		1 Yes	2 X No	1	Yes 2X	No so	ecify:		Specify:	U	SA
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72 hor "na"	etec	Elementary/Secondary (0-12	) College (	1-4 or 5+)	during n		g life. DO	NOT use retir	ed)			
5-0036 led within 7 Hygiene I other than the Medica	Completed	0				N/A				N/A		
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once		17. Father's Name (First, Middle UNKNOWN	e, Last)				1		(First, Middle, GOODW)	Maiden Surnam F N	e)	
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O gen in it		MARY JONES/		лмотиер	11111							ND 20743
e, N 1 and 1 and Health item		20a. Method of Disposition		20b.	Place of Dispo crematory or o	sition (Name o			Date	20c. Location	- City or	Town, State
nor ages ant of at: If		1 X Burial 2 Cremation  1 Donation 5 Other			SURREC:		EMETE	ERY 7/6	/2009	CLINTO	ON,M	ARYLAND
Baltimore, MI permit. Pages 1 and 2 v De artment of Health a pin. ream: If item 27	-	21. Signature of an all Service	e Licensee		22.	Name and Ad	dress of F	Facility J	B JI	ENKINS	FUNE	RAL HOME
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		29a. Certifier 1 Certifying	Physician: To the b	est of my knowle	dge, death occ	urred at the tir	ne, date a	and place, and	d due to the car	use(s) and man	ner as sta	ated.
To the Howithin 24 h	edical	one) 2 Medical Ex	kaminer: On the basi	s of examination stated.	and/or investig				at the time, dat			
- > - 3	ž	29b. Signature and title of certi		00			icense n					fonth, Day, Year)
		Pote Ch	15	Wh	~ ~		D.C.M.I	E.		June 23,	2009	
cal		30. Name and address of personal Patricia Aronica-Poll		use of death (Ite stant Medical		111 Per	n Stree	et Baltimo	re, MD 212	01		
CVL	ate											
Regist	ate trar	31. Day filed (N° 9) 2009	General	Registra 's Signa	aver							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** РМ Lucy Ryan Gaffney 27 2009 :15 6 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Atlantic General Hospital Berlin Worcester Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 K 046-12-9676 85 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Predical Experient interior cutting at 1 XYes 2 No Director MD Ocean City Worcester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 713 139th St. 21842 USA Funeral 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 X Married 0. のこの 06/27/2 Maryland 21215-0036 1 ☐Yes 2 ☑No Specify: ģ 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Mental Important: If item 27 is marked or any injury or other traumatic eve once. Pages 1 and 2 should be in nent of Health and Mental Lucy Freney George Ryan ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 713 139th St., Ocean City, MD 21842 James Gaffney / husband Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Cape Henlopen Crem. 6/29/2009 Frankford, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage FUneral Home 21. Signature of Funeral Service Licensee 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Colonic **Physician** disease or condition resulting in death) obstruction /Medical Due to (or as a consequence of): Examiner Samuel ally list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Year Month Day 5 Other (specify) ☐Yes 2 ☐No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to me examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Medical Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

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30. Name and addit

31. Date filed (Mon

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Tealthiay Drive Berlin

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AMEND TTEM#8&#19b,perINF,G893,7/14/09,WS
State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 5.00 PM 2009 County of Death vn, or Location of Death 4a. Facility Name (If not institution, give street and number) Cheverly George ince George Hospital 8. Date of Birth 1/04/19459. Birthplace (State or Foreign (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age Un Days Min 1 M 2□ F 229-23-8060 6 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 Yes 2 □ No Dring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Lee Valley 22150 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: Asian 3 ☐ Widowed 4 ☑ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) Mc Donald Elementary/Secondary (0-12) College (1-4or 5+) 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) <u>የ</u>ጄ/ጄ BEGUM IQBAL AHMED 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22150 19a. Informant's Name/Relationship (Type. Print) Valley Dr. # 1025 Springfield

Date 20d. Location Only or Town, Sta IKRAM UL HAQUE BROTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 128/2009 STAFFORD 6 MAA Cemetery 22. Name and Address of Facility Aden Muslim Funcint 21. Signature of Funeral Service Licenses Ser. 1242 Woodbridg Easy St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as bardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARRIVITIMIA +ATA! disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 😿 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Box 68760, P.O. Division of Vital Records,

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

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items 23a

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d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "r

Pages 1 and 2

Department of Health ar Important: If Item 27 Is any injury or other trau

Physician

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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Medical Certification: To

traumatic event, the the field at Examiner must be notified at

State Registrar TSION 31. Date filed (Month, Day, Year)

BERHANE

29b. Signature and title of certifier

32. Registrar's Signature

3001

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

CHEVERLY

DRIVE

29d. Date signed (Month, Day, Year)

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4	Physici /Medic		Evelyn Michael	Hicks						$rac{ ext{Month}}{ ext{u}  extbf{1}  ext{v}}$	Day Year 200	9 1:15 P <sup>M</sup>
6	Examin		4a. Facility Name (If not institution, give s	street and number)			4b. City, Town,	or Location		,	4c. County of Dea	th
4			1329 Salem Ave. 5. Social Security Number 6. Sex	7 Age	a (In vre	last birthday)	Hager If Under 1 Yea	stown r If Under		Date of Birth	Washin	gton thplace (State or Foreign
r.	Funeral Director			M 2M F 79°	9 (117)	Vro	Months Day		Min. (	Month, Day, Y	ear)	Jersey
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	the N	Director	MD Washingto	)[]	нае	gerstow	/II 10f. Zip Code			100	j. Citizen of What Co	ountry?
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	ems er mu	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Ori	igin? (Specify n, Puerto Rica	Yes or No-	14. Race - Ame Black, Whi	
36	s afte ", or it ta⊡in	by Ft	1 ☐ Never Married 2 ☐ Married 3 점 Widowed 4 ☐ Divorced	1 ☐ Yes 2 X N If Yes, Give Year or Dates:	VO.		1⊡Yes 2ÑIN				Specify: B	
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	ted t	15. Decedent's Educ	cation			dent's Usual Occ			16	b. Kind of Business	/Industry
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2	led wi lygien her th nt, the	S	8th			Assem	bler_	10 Math	ada Nama /Fi		strument	Pane1
anc	d be fi	Be c	17. Father's Name (First, Middle, Last)  James C. Reese					Isad	,		iden Surname) _chae1	
ary.	should nd Me mark umatik	욘	19a. Informant's Name/Relationship (Ty)	pe. Print)		19b. Mailir	ng Address (Stree				City or Town, State,	Zip Code)
	and 2 salth a 27 is		Linda E. Norringto	n / Daugh	iter	1329	Salem A	ve. Ha	gersto	wn, MD	21740	
altimore,	of He		20a. Method of Disposition 1 ☐ Burial 2 ▼ Cremation 3 ☐ R	lemoval from State	20b. F	Place of Dispo cemetery, crei	sition (Name of matory or other p	lace)	Date	20	c. Location - City or	Town, State
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Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy oriquity or other traumatic event, the Medical Examiner must be notified at one.		21. Signature of Funeral Service License				2. Name and Add		Gera.		Minnich Fu wn, MD 21	neral Home 1740
Н			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	ications that caused ne cause on each lir	the deat	h. Do not ent	er the mode of d	ying, such as	cardiac or res	spiratory arres	t,	Approximate Interval Between Onset and Death
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Box	h certii ending use a	M/u	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome			∃Ectopic pregnar				23d. Date of de	livery
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	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C	29a. Certifier 1 ☑ Certifying Phys (Check only one)	sician: To the best oner: On the basis of and manner sta	examina	wledge, death	h occurred at the vestigation, in m	time, date ar y opinion, dea	nd place, and ath occurred a	due to the cau at the time, dat	se(s) and manner a e and place, and du	s stated. e to the cause(s)
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•			Dan H. M	c Douge	al		D 23	1.470			July 2, 2	2009
,			30. Name and address of person who co							1110 M	edical Camp	us Road
2	H-4 Sta	to	Dan H. McDougal, 31. Date filed (Month, Day, Year)	MD Suite 32. Registra	229	Robin	wood Med	dical	Center	Hagers	town, MD 21	742
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DHMH 17 Rev 1/2001

**ORIGINAL** 

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician 2009** 4:04P Harrell June 24, William George /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel 938 St. George Barber Rd
5. Social Security Number 6. Sex 7 Davidsonville If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 9. Birthplace (State or Foreign 8. Date of Birth 9/14/1934 7. Age (In yrs. last birthday) **Funeral** Hours 1 X M 2 □ F Virginia 74 578-44-9953 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 X No Director Davidsonville Maryland | Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 938 St. George Barber Rd. 21035 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 ⊠Yes 2 □ No 1957— If Yes, Give Year or Dates: 1960 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: \$ Specify: White 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Musician Entertainment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William James Harrell Edna Atkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) William M. Harrell/Son 938 St. George Barber Rd. Davidsonville, MD, 21035 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation / 5 ☐ Other (Specify) Lakemont Mem. Gardens 6/29/2009 Davidsonville. MD. 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signatur Funeral Service Licensee 2973 Solomons Island Rd. Edgewater, MD. 21037 elas 23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** STROUS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy 5 Other (specify) 1 ☐Yes 2 ☐No detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1. Yes 2 No 3 Probably 4 Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page 1 ☐ Yes 2 ☐ No rustate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ☑ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) To the I within 2 and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D33069 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Richard Bernstein, M.D. Highe Detense Ste log Huncipolis 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

**JUN 26** 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) June 26, <sup>Day</sup> 2009 **Physician** Feliza Iglesias /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Montgomery 8601 Manchester Road, #521 Silver Spring If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth (Month, Day, May 1, 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year) 1925 1 □ M 2 1 F Country) B**olivia** Months Days Hours Min. 577-48-1723 84 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Directo Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8601 Manchester Road, #521 20901 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Bolivian If Yes, Give Year or Dates 1 XYes 2 No Specify: Completed by Specify: 3 ☐ Widowed XX Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cosmetologist Salon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bartholemew Sanchez Adrianna Maldanado ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rudy C. Iglesias/Son 8221 Tall Trees Court, Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State June 2009 30 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify)

Physician /Medical Examiner 23a. i

Imme disea result

Seque if any,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shot any injury or other traumatic event, In Medical Examinant to the resumatic at the medical and injury or other traumatic event, In Medical Examination and the modified at

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Division of Vital Records,

or items 23a or 28a-f show

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and attending physician ed by the detached t אושו נחוא certificate has been signed infuneral director, page 2 should be det Medical Certification: To

gnature of Funeral Service L	icensee Cole	22. Name and Address of Facility. Francis J. Collins Funer 500 University Blvd. W.,	al Home Inc. Silver Spri	ng, MD 20901
Part1. Enter the disease, or o shock, or heart failure. List o	complications that caused the death. Do no only see cause on each line.	t enter the mode of dying, such as cardiac or respirator	y arrest,	Approximate Interval Between Onset and Death
diate Cause (Final se or condition ng in death)	Pneumonia			days
entially list conditions,	Due to (or as a consequence of) Failure To Thris			weeks
leading to immediate  (Disease or injury itiated events	Due to (or as a consequence of)	:		
ng in death) Last	Due to (or as a consequence of)	:	-	
	d			
MALE: Vas decedent pregnant	23c. If yes, outcome of pregnancy	a.C.a.	23d. Date of d	elivery

Examiner Physician/Medical of delivery Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 2 X No

25	Was case referred to medical examiner?			26. Place of Deat	th (Check only one)
	1 ☐ Yes 2 🔀 No	Hospital: 1 🔀 Inpatient 2 [	☐ ER/Outpatient 3[	Other: 4 Nursing Ho	ome 5 Residence 6 Other (Specify)
27	. Manner of Death  XX Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury	Work?	28d. Describe how injury occurred
	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		home, farm, street, fa	factory, office	28f. Location (Street and Number or Rural Route City or Town, State)

29a. Certifier (Check only one)		cian: To the best of my knowledge, death occuer: On the basis of examination and/or investig and manner stated.		
29b. Signature and	title of certifier		29c. License number	29d. Date signed (Month, Day, Year)

29b. Signature and little of certifier

21. Signatur 0 Funeral Service Licensee

June 26, 2009

3. Time of Death

10d. Inside City Limits

Number.

1 ☐ Yes 2 No

2:50 p M

30. Name and addre s of person who completed cause of death (Item 23a) (Type, Print) Suresh K. Gupta, MD

9801 Georgia Avenue, #220, Silver Spring, MD 20902

D32332

State Registrar

filled in by

To the Hospital of within 24 hours at To the Funeral D

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland				and Me	ntal Hyg	jiene		
			1 _ State Registrar	Cer	tificate of L	Death			eg. No.	2009	22424
	Physici	ian	1. Decedent's Name <i>(First, Middle, Last)</i> Broadway Jackson	Sr				Date of Dea Month	Day	Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give street and number)	21	4b. City, Town, or	Location o		June_	25	2009 County of Death	18:10 P M
	Examir	ier	Prince Georges Community Hospit	al	Chever1		Dodan			ince Ge	
Ε	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. las	t birthday)	If Under 1 Year Months Days	If Under 2	24 Hrs. 8. Min.	Date of Birth (Month, Day	Year)	9. Birth	nplace (State or Foreign untry)
	Director		238-44-5986	Yrs.	monard Bayo	110013		0/21/1			th Carolina
	land ow			Town or Lo	cation						10d. Inside City Limits
	Mary a-f sh	햦	MD Prince Georges Land	over							1kgYes 2□No
	or 28	Dire	10e. Street and Number		10f. Zip Code			1	0g. Citiz	en of What Cou	untry?
	ath wi	Funeral Director	7609 Muncy Rd.		20785					JSA	
	items	-une	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of Hi f Yes, specify Cuba	spanic Orig n, Mexican	gin? (Specif , Puerto Ric	y Yes or No- an, etc.)	1.	<ol> <li>Race - Amer Black, White</li> </ol>	
93	al", or	by	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	□Yes 2∏No	Specify:				Specify: B1	ack
9200-91717	72 hor	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupa kind of work done of	ation	of working		16b. Kin	d of Business/I	ndustry
121	/ithin ne.	E E	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	OO NOT use retired	)	or working				
N	filed v Hygie tther t	ပ္ပိ	12th 17. Father's Name (First, Middle, Last)	U.	ab Driver		r's Name (F	irst, Middle,		rivate	
yland	is 1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinations by nothing at	To Be	Thaddeus Purcell				nie	Bell		ckson	
Mary	shou and M s mar	-	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	g Address (Street a						ip Code)
Ξ	and 2 ealth a n 27 l		Shirley Bell-Jackson/ Wife	7609	Muncy Rd	. Lan	dover	_MD_	_207	85	
o G	Pages 1 nent of H int: If iter iny or oth				sition (Name of natory or other place		Date		20c. Loc	ation - City or 1	own, State
saitimore,	t. Pag rtmen rtant:		4 □ Donation 5 □ Other (Specify) Harr		Memorial						Maryland
<u> </u>	permit. Pages Department of Important: If it any Injury or o		21. Signature of tuneral Service Licensee		. Name and Addres 474 Lando		A * D *	Jenki	ns F	uneral	
			23a. Part 1. Enter the research or complications that caused the death.							D 207	Approximate
F	Physician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition Fatal Cardi	iac Aı	rrvthmia						Interval Between Onset and Death
	/Medical		resulting in death)  Due to (or as a consequer	nce of):	- L y Chimza						
	Examiner	_	Sequentially list conditions, B. Hypertensio								15 yrs
	nsit	nine	Sequentially list conditions, and the conditions of the cause. Enter Underlying Cause (Disease or injury Chronic Obs		ive Pulmo	nary	Disea	se			15 yrs
,	execu n and ial-tra	Examiner	that initiated events c c	nce of):			.,.				
8/00,	ficate be executed physician and s the burial-transit	dical	d								
9	ertifica ling ph e as th		IF FEMALE:								
Š	eath certific attending p	sician/M	23b. Was decedent pregnant   23c. If yes, outcome of pregnanc	eath 3	Ectopic pregnancy	1			2:	3d. Date of deli Month	very Day Year
<b>S</b>	the de y the	ıysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of dea 9 ☐ Unknown	ıtn 5∟	Other (specify)						
, T	s that ned b e deta	by Phys	Part II. Other significant conditions contributing to death but not resulting	ng in the ur	iderlying cause give	en in Part I.		23e. Did to	bacco us	e contribute to	the cause of death?
ğ .	equire en sig xuld bi						_ 1	1 □ Y	es 2	]No 3□ Pro	obably 4冝 Unknown
Hecords,	The law requires that the death certificate has been signed by the attending bage 2 should be detached for use as	Completed						24a. Was a	n	24b. Were au	topsy findings available ompletion of cause of
ב קי	the cate h	ပ္ပြ						perfor	med? 210 No	death?	2 🗆 No
VII.	Physician: r this certifica ral director, p	Be	25. Was case referred to medical examiner?	-	Otho	· · ·		heck only or			
5 i	Phys er this eral dii	2	1 Inpatient 2 SI EF	R/Outpatien  Bb. Time of		4 🗆 1401		5 ☐ Resid		Other (Spec	eify)
VISION	nding ath. r: Afte e fune	atio	1 Natural 5 Pending (Month, Ďay, Year) 2 Accident investigation	Injury	Work	? /es 2 □ N			,u.,	0000.100	
<u> </u>	r Atte er dez recto	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	eet, factory, office		28f.	Location (S City or Town		Number or Ru	ral Route Number,
<u>.</u>	ntal o Insaft ral Di										
:	to the hospital or Attending Physician: The law requires that the de within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Medical	29a. Certifier (Check only one) (Check only one) (Check only one)	edge, death n and/or inv	occurred at the ting estigation, in my op	ne, date an pinion, deat	d place, and th occurred	d due to the o at the time, o	ause(s) late and	and manner as place, and due	stated. to the cause(s)
:	vithin Fo the	Me	29b. Signature and title of certifier		29c. License	number		2	9d. Date	signed (Month	, Day, Year)
			our au		D 34	722	No.		6-	26-	04
0	и		39 Name and address of person who completed cause of death (Item 2:	, , , , ,	,						· · · · · · · · · · · · · · · · · · ·
4	-64	to.	Dr Vicken Poochikan 5632 Annap  31. Date filed (Month, Day, Year)  32. Registrar's Signatur	~ ~~~	Rd. Suite	e #3,	Blade	nsbur	g, MI	2071	0
	Sta Registr		JUL 0 1 2009 Server A. A.	Mes 1							

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Oretha Wava Kelley 6:25 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Dennett Road Manor Nursing Home 0akland Garrett If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 💢 F Yrs Director 212-24-0097 Aug. 13 1924 | West Virginia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show be notified at Yes 2 No Director MD Garrett 0akland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 2 and 1 may injury or other traumatic event, the Medical Examiner must be no once. 400 Glades Square, Apt. 32 Completed by Funeral 21550 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry S. Lewis 2 Calvia White 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vicky Kelley, Daughter 400 Glades Square, Apt. 32, Oakland, MD 21550 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrett Memorial Gardens 7/2/2009 Oakland, MD 22. Name and Address of Facility David A. Burdock Funeral Home, 21 N. Second St., Oakland, MD 21. Signature of Funeral Service Licenses atherine Sweits 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner for use as the burial-tran and as a consequence of) ed by the attending physician detached for use as the buria Physician/Medical IF FFMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 21 No 9 Unknow ate has been signed by t page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 **X**No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Certification: To 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 within 24 hours after death To the Funeral Director: in by

> State Registrar

Medical

(Check only

30. Name and address d

and title of certifier

29b. Signatur

DHMH 17 Rev 1/2001

0 1 2009

Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ror State Registrar/Amend#26.PerPhys.PC7-1-09cr Certificate of Death Reg. No. (... 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** 6.29 A M 2009 HAMIYET KERMAN June /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick Memorial Hospital 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 💢 F 75 1934 TURKEY 212-85-5894 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hjury or other traumatic event, it is Martiel Examiner in ust be notified at once. Frederick 1 XYes 2 □ No MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21702 lurkey Completed by Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 \_Yes 2 VNo If Yes, Give 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) home College (1-4or 5+) Home maker 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be BEHICE CUNTA 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1911 BELFORD COURT FREDERICK MD. 21702 ALPER A. KERMAN SON 20b. Place of Disposition (Name of cemetery, crematory or other place)
AL-FIRDAUS MEMCARDENS Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State June 27, 09 Frederick 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Aden Muslim Funeral Ser 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease **Physician** coronary 1005 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months 1 Yes 2 No 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O. I 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by of Vital Records, heart 1 Yes 2 No 3 Probably 4 Unknown hypertension 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 25. Was case referred to medical examiner? choles tero 1 ☐ Yes 2 ☐ No 1 □ Yes 2 □ 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Note that Injury at 28d. Describe how injury occurred Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Medical Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Natural 5 ☐ Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 09 w 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21703 610 Solarex Heitzia 31. Date filed (Month, Day. )

JUL 0 1 2009 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - For State Registrar #11,20b, perF. Home, 6/29/09BA Certificate of Death WCHD 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 24<sup>Day</sup> Month 6 Physician Betty Evelyn Kleindienst 2009 10:50 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 36 Mystic Harbor Blvd. Berlin Worcester 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year 6/17/1932 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 X □ F 579-40-8257 77 Director MD Usual Residence of Decedent the Maryland 10a. State la or 28a-f show the notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ▼No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or any or other traumatic event, the Medical Exerction in ust be a 36 Mystic Harbor Blvd. Funeral 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electronic Technician Naval Research Lab 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Maurice Francis 2 Evelyn Townsend 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and:
Department of Health
Important: if item 27
any Injury or other tra Renee Sechrist / daughter 36 Mystic Harbor Blvd., Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State Cape Henlopen Crem. 4 ☐ Donation 5 ☐ Other (Specify) 6/28/2009 Frankford, DE 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on part of the complex of the cause on part of the cause o cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death ANCREATIC Immediate Cause (Final CANCER Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknowf Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 icate has been si , page 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate perform 2 □ No 1 ☐ Yes 2 No 1 ☐ Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 140 1∐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Natural 2 Accident n 24 hours after death.

e Funeral Director: A letely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MNO 6-25-09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RA 10 Waters Stephen am 1001 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 **Physician** Joseph C. Kordella June 26, 12:40 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 10110 Ashwood Drive Kensington Montgomery Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 □ F Days Hours Min. 217-01-6766 90 **Director** Aug. 11, 1918 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Modical Examiner", out by notified a once. Director 1 Yes 2XXNo Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10110 Ashwood Drive 20895 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White ğ If Yes, Give Year or Dates: 1942-45 Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Director of Public Works County Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Blazic Kordela Mary Snyder ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claire F. Kordella/Wife 10110 Ashwood Drive, Kensington, MD 20895 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State June 30 2009 Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) Rockville, Maryland 22 Name and Address of Facility
Francis J. Collins Funeral Home
500 University Blvd. W., Silver 21. Signature of Funeral Service Licen Home ichen MD 20901 23a. Part 1. Enter the disease, or complitations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Gastrointestinal Hemorrhage resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Diverticulosis, Gastroesophageal Reflux Disease, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertension, Dementia autopsy 2 No 1 □ Yes 2 K No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🔼 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No

Box 68760. P.0. Division of Vital Records,

in by the funeral

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and e Funeral I

To the within 2

20+1

State

Registrar

Medical

3 Suicide

29a. Certifier

29b. Sign

one)

4 Homicide

(Check only

end manner stated. tore and title of certifier

29c. License number

🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month. Day, Year)

June 26, 2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed payse of death (Item 23a) (Type, Print)

George Sengstack, MD

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

3929 Ferrara Drive, Silver Spring, MD 20902

D12121

31. Date filed (Month, Day, Year) 2. Registrar's Signature JUN 29

6 □ Could not be

**Physician** 

/Medical

31. Date filed (Month, Day, Year)

JUN 29

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Director

Funeral

Completed by

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Physician/Medical Examiner

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Be Completed

Certification: To

Medical

<ul> <li>State Registrar</li> <li>Decedent's Name (First, Middle</li> </ul>		aryland / Depa <i>Cer</i>	rtificate of				00100
Decedent 5 Name (First, Minne	Last)	061	UI ,		Reg. N	2003	3. Time of Death
Rodman R. Kenna	-				Month D	2009 Year	545 A M
a. Facility Name (If not institution,			4b. City, Town, o	r Location of Death		4c. County of Dea	
Manor Care Poto	mac		Potoma	С		Montgome	
. Social Security Number	6. Sex 7. Age	e (In yrs. last birthday)	If Under 1 Year Months Days	Hours Min.	B. Date of Birth (Month, Day, Yea	ar) $Cc$	thplace (State or Foreign
156-16-2243	1 M 2 □ F	83 Yrs.	2493		ug 14, 19	925 New	Jérsey
Usual Residence of Decedent  Oa. State 10b. County		10c. City, Town or Loc	ation				10d. Inside City Limits
	omery	Rockvill					1XIYes 2 □ No
Oe. Street and Number	J	OK V 111	10f. Zip Code		10g. (	Citizen of What Co	ountry?
10401 Grosvenor	Place #1021	l	20852			ited Stat	•
1. Marital Status	12. Was Decedent I			lispanic Origin? (Speci an, Mexican, Puerto Ri		14. Race - Ame	erican Indian,
1 ☐ Never Married 2 ☐ Marri	Armed Forces? ed 1 1√2 Yes 2 □ N	No 1		an, Mexican, Puèrto Ri Specify:		Black, Whit	.,
3 ☐ Widowed 4 【 Divorced	If <del>Y</del> es, Give Year or Dates:	44-46	I∐Yes 2∏X No			1	lack
15. Decedent (Specify only highes	s Education	16a. Deced	lent's Usual Occup	pation during most of working d)	16b.	. Kind of Business	/Industry
Elementary/Secondary (0-12)	College (1-4or 5	i+)		u)		ty of Di-	iladelphia
7 Father's Name (First 1997)	4 ast)		neer	18. Mother's Name (i			macihiiig
17. Father's Name (First, Middle, I Hermogenes Zaba				18. Mother's Name (i		Junaine)	
		47th 1 * * ***	g Address (Ct	-		Vor Town Care	Zip Code)
19a. Informant's Name/Relationsh Mary Kennard/Da				and Number or Rural I od Lane, B			
Mary Kennard/Da Oa. Method of Disposition	-0.1001	20b. Place of Dispos	sition (Name of	Dat		Location - City or	
1 ☐ Burial 2 X Cremation		cemetery, crem	natory or other plac	ce)		•	
4 □ Donation 5 □ Other (Sp				atory 06/30		rentwood	, rii/
21. Signature of Funeral Service	M.	Ullus		ess of Facility Sim: Eville Pike	4		20850
23a, Part1 EnterAnd disease	complications that course					, LID	Approximate
23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final				g as varuide of	,ry arrest,		Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a	er Carcinom	na				Years
	Due to (or as	a consequence of):					
Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):					
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	S to to as	, 5./.					
that initiated events resulting in death) Last	C. Due to (or as	a consequence of):					
	C <sub>d</sub>						
	23c. If yes, outcome		Tester!			23d. Date of de	
			]Ect <i>o</i> pic pregnanc ] Other <i>(specify)</i> _	у		Month	Day Year
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No							
23b. Was decedent pregnant in the past 12 months?	9□Unknown	-					
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  Part II. Other significant condition	9□Unknown		nderlying cause giv	en in Part I.			to the cause of death?
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	9□Unknown		nderlying cause giv	en in Part I.			to the cause of death?  Probably 4 Unknown
23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  Part II. Other significant condition	9□Unknown		nderlying cause giv	ven in Part I.	1½ Yes 24a. Was an	2 No 3 F	Probably 4 □Unknown
23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  art II. Other significant condition	9□Unknown		nderlying cause giv	en in Part I.	1 Yes  24a. Was an autopsy	2 No 3 F	Probably 4 Unknown autopsy findings available completion of cause of
23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant condition  Advanced Coror	9□Unknown		nderlying cause giv	ven in Part I.	1 Yes  24a. Was an autopsy performed 1 Yes 2 🖺	2 No 3 F	Probably 4 Unknown
23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown Part II. Other significant condition	9□Unknown	)isease	Cott	26. Place of Death (	1 Yes  24a. Was an autopsy performed 1 Yes 2 🖺	2 No 3 F  24b. Were a prior to death? No 1 Ye	Probably 4 □Unknown autopsy findings available completion of cause of s 2 □ No
23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant condition  Advanced Coror  25. Was case referred to medical examiner?  1 □ Yes 2 ☒ No  27. Manner of Death	9 Unknown  Ins contributing to death be ary Artery D  Hospital: 1 Inpatie	Disease  ent 2 ER/Outpatien  ry 28b. Time of	ıt 3□ DOA Oth	26. Place of Death (	1 Yes  24a. Was an autopsy performed 1 Yes 2 (Check only one)	2 No 3 F  24b. Were a prior to death? No 1 Ye	Probably 4 □Unknown autopsy findings available completion of cause of s 2 □ No
23b. Was decedent pregnant in the past 12 months?  1	9 Unknown  Ins contributing to death beary Artery Description  Hospital: 1 Inpatie (Month, Danation)	Disease  ent 2 ER/Outpatien  ry 28b. Time of	nt 3□ DOA Oth f 28c. Inju	26. Place of Death (	1 Yes  24a. Was an autopsy performed 1  Yes 2 E  (Check only one) e 5  Residence	2 No 3 F  24b. Were a prior to death? No 1 Ye	Probably 4 □Unknown autopsy findings available completion of cause of s 2 □ No
23b. Was decedent pregnant in the past 12 months?  1   Yes   2   No   9   Unknown  Part II. Other significant condition  Advanced Coror  25. Was case referred to medical examiner? 1   Yes   2   No    27. Manner of Death 1   Natural   5   Pendin investig   3   Suicide   6   Could restricted	9 Unknown  Ins contributing to death beary Artery Description  Hospital: 1 Inpatie (Month, Dalation of bear)  28a. Date of Injunction of bear 28e. Place of injunction bear 28e. Place of injunction of the contribution of the co	Disease  ent 2 ER/Outpatien  try y Year)  28b. Time of Injury  ury - At home, farm, str	nt 3□ DOA Oth f 28c. Inju M 1□	26. Place of Death ( ner: 4	1√ Yes  24a. Was an autopsy performed:  1	2 No 3 F  24b. Were a prior to death? No 1 Ye  6 Other (Sp. njury occurred	Probably 4 □Unknown autopsy findings available completion of cause of s 2 □ No
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3b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  art II. Other significant condition  Advanced Coror  5. Was case referred to medical examiner? 1 □ Yes 2 ☒ No  7. Manner of Death 1 ☒ Natural 5 □ Pendin investig 3 □ Suicide 6 □ Could referred to medical examiner?  2 □ Accident investig 3 □ Suicide 6 □ Could referred to medical examiner?	9 Unknown  Ins contributing to death broad ary Artery Description  Hospital: 1 Inpatie  28a. Date of Injuty (Month, Date of Injuty) 28b. Place of Injuty building, etc.  29 Physician: To the best Examiner: On the basis of	ent 2 ER/Outpatien  Iny y Year)  28b. Time of Injury  ury - At home, farm, stre c. (Specify)  of my knowledge, death of examination and/or in	at 3 DOA Oth  f 28c. Inju Wo M 1 eet, factory, office	26. Place of Death ( ner: 4 X Nursing Homry at rk?   Yes 2 No 28	1 Yes  24a. Was an autopsy performed 1 Yes 2 Yes  (Check only one)  e 5 ☐ Residence ad. Describe how in the course of the cours	2 No 3 F  24b. Were a prior to death? 1 Lye  6 Other (Spanjury occurred)  and Number or F  tand Number or F  tand Number or F	Probably 4 Unknown autopsy findings available a completion of cause of s 2 No ecify)  Rural Route Number, as stated.
3b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  art II. Other significant condition  Advanced Coror   5. Was case referred to medical examiner? 1 □ Yes 2 ☒ No  7. Manner of Death 1 ☒ Natural 5 □ Pendin investig all conditions investig all conditions are referred to medical examiner?  1 ☒ Accident investig all conditions are referred to medical examiner?  1 ☒ Certifier (Check only) 2 ☐ Medical	9 Unknown  Ins contributing to death be contributing to death be contributed and the contribution of the c	ent 2 ER/Outpatien  Iny y Year)  28b. Time of Injury  ury - At home, farm, stre c. (Specify)  of my knowledge, death of examination and/or in	at 3 DOA Oth  f 28c. Inju Wo M 1 eet, factory, office	26. Place of Death ( ner: 4 X Nursing Homery at rk?  Yes 2 No  28  ime, date and place, ar opinion, death occurred	1 Yes  24a. Was an autopsy performed: 1 Yes 2 12  (Check only one)  e 5 Residence 3d. Describe how in  3f. Location (Street City or Town, St and due to the caused at the time, date	2 No 3 F  24b. Were a prior to death? 1 Lye  6 Other (Spanjury occurred)  and Number or F  tand Number or F  tand Number or F	Probably 4 Unknown autopsy findings available completion of cause of s 2 No ecify)  Bural Route Number, as stated. le to the cause(s)

State Registrar 20814

Loreto S. Albiol, M.D., 8218 Wisconsin Avenue, Bethesda, MD

Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legio.e.

			For State Registrar	State of Marylan		artment of H			giene Reg. No. 00	22430		
	Physici /Medic	an	1. Decedent's Name (First, Middle, Last	LEVY	/	• .		2. Date of De.	1020	ear 530 P M		
	Examir	er	4a. Facility Name (If not institution, give	EY NURSING,	-	4b. City, Town, or Rock U	Location of Dea		4c. County of			
	Funeral Director		5. Social Security Number 6. Se 219–48–0566		7 . Yrs.	Months Days	Hours Min		, 1922	Maryland		
re, Maryland 2121	Aaryland f show	Director	10a. State 10b. County  MD Montgome		y, Town or Lo					10d. Inside City Limits 1X Yes 2 □ No		
	with the has or 28a-1		10e. Street and Number 1235 Potomac Valley Road			10f. Zip Code 208.	50	10g. Citizen of What Country? United States				
	72 hours after death with the Maryland Insturat', or Itema 23a or 28a-f show dical Exeminat traval or invilited at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 🕅 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 X No ff Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (	Specify Yes or No rto Rican, etc.)		American Indian, White, etc. White		
	within 72 hou ene. than *natura na Medical E	Completed b	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) Unknown	ıcation	ompleted) (Give kind of w life. DO NOT		of work done during most of working OT use retired)			16b. Kind of Business/Industry Unknown		
	id be filed v ental Hygie ked other i	To Be Co	17. Father's Name (First, Middle, Last) Unobtainable		<u> </u>		18. Mother's Name (Firs Unobtainal		, Maiden Sumame)			
	ges 1 and 2 should be filed within 72 hours alter death with the Manjar It of Health and Mental Hygiene. If item 27 is marked other than "natural", or Itema 23a or 28a-f show or other traumatic event, the Madical Executivant Karnkillied at		19a. Informant's Name/Relationship (T) Sherry Davis/Guar 20a. Method of Disposition	dian	401		d Drive		er, City or Town, Stoor, Rock	ville, MD 2085		
	permit. Pages Department of I Important: If it eny injury or o		1 ☐ Burial 2 【XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Fuperal SerVice License)	For	t Linc	oln Crema 2. Name and Addre	tory 06	Simple Ti	ibute	od, Maryland		
8	80558		23a. Part1. Enter the disease, or comp shock, or yeart failufe/ List only of	lications that caused the deat					rille, MD	Approximate Interval Between Onset and Death		
of Vital Records, P.O. Box 68760,	death certificate be executed  The attending physician and attending physician and attending physician and attending for use as the burial-transit	edicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	uence of):	arryti	<u>hm (</u>	α.				
	ne death certifi the attending thed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. ff yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	aldeath 31	⊒Ectopic pregnancy □ Other (specify)	y		23d. Date Monti			
	uires that the signed by ald be detacted	Ď	Part ff. Other significant conditions of	underlying cause giv	ven in Part I.	23e. Did		co use contribute to the cause of death?  2 \times_No 3 \subseteq \text{Probably 4 \subseteq Unknown}				
	The law requires that sate has been signed b page 2 should be deta	Completed	Parknisonis 24						. Was an autopsy findings available prior to completion of cause of death?  Yes 2 No 1 Yes 2 No			
	Physician: This certificated director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 爲 No	Hospital: 1 ☐ Inpatient 2 ☐		n (Check only one)  me 5 ☐ Residence 6 ☐ Other (Specify)						
	ding After fune	ation: T	27. Manner of Death  1. Natural 5 Pending 2 Accident investigation						d. Describe how injury occurred			
Divis	P in te	Certification:	3 Suicide 6 Could not be 4 Homicide determined						tion (Street and Number or Rural Route Number, or Town, State)			
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	(Check only 2 Medical Exam	/sicien: To the best of my knowner: On the basis of examination and manner stated.	ation and/or i	nvestigation, in my o	opinion, death oc	curred at the time,	date and place, an	id due to the cause(s)		
	To the within 2 To the comple	W	29b. Signature and title of certifier	Sm	•	29c. Licens	se number 0624	35	29d. Date signed	(Month, Day, Year)		
			30. Name and address of person who as the filed (Month, Day, Year)  JUN 29 2009	ompleted cause of death (fter	m 23a) (Tybe	Colar De	. Rock	Fuille,	MD 70	0850		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  JUN 29 2009	32. Registrar's Sign	ature	N. J.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1	For State Registrar		-			of Death	and Me		Reg. No 2	09	22431	
		Decedent's Name (First, Middle, Last)				2	2. Date of Dea Month	ath Day	Year	3. Time of Death			
⁄sicia ledic		Nancy Lee de Lask	Nancy Lee de Laski								10:40 A M		
amine		4a. Facility Name (If not institution	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of D							th 4c. County of Death			
		8300 Burdette Road	apt. 670			Bethesda				Montge			
eral		5. Social Security Number	6. Sex	7. Age (In yrs	. last birthday)	If Under 1 Y Months D	ear If Under	24 Hrs. 8	B. Date of Birt (Month, Da	th y, Year)	9. Birthp	place (State or Foreign ntry)	
ctor		579-46-4700-A	1□M 2፟□F	74	Yrs.		,	S	eptembe	r 5 1934	Washi	ngton, DC	
603	7	Usual Residence of Decedent  10a. State 10b. County		100.0	itv. Town or Lo	cation					1	0d. Inside City Limits	
중						odion						1 ∐Yes 2 No	
elle elle	Director	MD Montgom	ery	pe	thesda	106 7in Co	40			10g. Citizen of	What Cour	ntry?	
		10e. Street and Number				10f. Zip Co	de			rog. Onizen or	Wilat Coul	шу.	
	Funeral	8300 Burdette Road			1.0	2081		ining (Cons	ifu Von er No	USA	oo Americ	can Indian	
	Ĭ.	1. Marital Status 12. Was Decedent Ever in Armed Forces?		J.S. 13.	Or Hispanic Or Cuban, Mexicai	ispanic Origin? (Specify Yes or No- an, Mexican, Puerto Rican, etc.)			<ol> <li>Race - American Indian, Black, White, etc.</li> </ol>				
	by F	1 ☐ Never Married 2 🔼 Married 3 ☐ Widowed 4 ☐ Divorced	If Yes. G	1 □Yes 2 🔀 No If Yes, Give Year or Dates:		1 ☐ Yes 2 2 No Specify:			Specify:		fy: Wh	White	
				Dales.	16a Dece	dent's Usual C	ccupation			16b. Kind of E	Business/In	dustry	
	ompleted	(Specify only highest grade completed) (Give k				kind of work o	st of working		Tob. Nilla of Dasificsor financially				
ŝ	ш	Elementary/Secondary (0-12)	_	College (1-4or 5+) 4		Realtor			Peal		Estate		
	0	17. Father's Name (First, Middle,			Near	COL	18. Moth	er's Name (	(First, Middle	, Maiden Surna			
	m	, , , , , , , , , , , , , , , , , , , ,	Aram Par	nossian			M	ary Rya	ale				
	۴.	19a. Informant's Name/Relations		10351411	19h Maili	na Address (S				er, City or Towi	n, State, Zij	o Code)	
Important: If item 27 is marked other any injury or other traumatic event, if once.			,									,	
	Į.	Donald de Laski -	nuspand	20b.				. 670 L Da		20c. Location		own, State	
	1	1 Burial 2 ☐ Cremation		1 State	Place of Dispo cemetery, cre		1						
		4 □ Donation 5 □ Other (S		Na	tional Mo					Falls Ch		VA	
DC6		21. Signature of Funeral Service	Licensee	0.4	7.	400 Too I	li abres	"'Natio	nal Fune	eral Home VA 22042			
OI	_	Joannale	Julia	ry_					<u>·</u>			Approximate	
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each une.							irrest,		Interval Between Onset and Death		
ın		Immediate Cause (Final disease or condition Amvotrophic Lateral Sclerosis vears										years	
al er		resulting in death)	Due to	o (or as a conse	equence of):								
	_	Sequentially list conditions,	b										
	ine	Sequentially list conditions, if any, leading to immediate cause. Little Underlying Cause (Disease or injury	Due to	o (or as a conse	equence or):								
	Examiner	that initiated events c.											
physician and the burial-transit													
	edical		d										
	Me	IF FEMALE:	220 15 100 0	utcome of pres	nancy					204 5	Nata at dali		
	Physician/M	23b. Was decedent pregnant  1 ☐ Live birth 2 ☐ Fetal death 3 [				☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of delivery  Month Day Year				
	sic	1 □ Yes 2 ♣ No 9 □ Unknown	9 Uni		r death 5	□ Otner (spec	(y)						
- 1	Ph		ons contributing to	death but not re	esulting in the u	underlying caus	e given in Part	1.	23e. Did	tobacco use co	ntribute to	the cause of death?	
	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						1.00	1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown				
							3		1 -	Yes 2 No	3 ☐ Pro		
	ted												
	npleted								24a. Was	s an 24t	o. Were aut		
	Completed								24a. Was	an 24t	o. Were aut prior to c death?	opsy findings available	
	3e Completed	25. Was case referred to medica						ce of Death	24a. Was auto perf	s an 24b opsy ormed? 2 No	o. Were aut prior to c death?	opsy findings available ompletion of cause of	
	o Be	25. Was case referred to medica examiner? 1 □ Yes 2 Å No	Hamitali	] Inpatient 2	□ ER/Outpatie	ent 3 □ DOA	26. Plac	Nursing Hom	24a. Was auto perf 1 □ Yes ( <i>Check only</i>	s an 24t ppsy ormed? 2 No one)	o. Were aut prior to c death? 1 □ Yes	opsy findings available ompletion of cause of 2  No	
	o Be	examiner? 1 ☐ Yes 2 💆 No 27. Manner of Death	Hospital: 1 [ 28a. Dat	□ Inpatient 2 te of Injury onth, Day, Year	28b. Time	ent 3 DOA	26. Plac Other: 4 □ N Injury at Work?	Nursing Hon	24a. Was auto perf 1 □ Yes ( <i>Check only</i>	s an 24b ppsy ormed? 2 No	o. Were aut prior to c death? 1 □ Yes	opsy findings available ompletion of cause of	
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	o Be	examiner? 1 ☐ Yes 2 💆 No  27. Manner of Death 1 🖺 Natural 5 ☐ Pendin	Hospital: 1 [28a. Dat (Mo) gation not be placed 28e. Placed 26e. P	te of Injury	28b. Time Injury	ent 3 DOA	26. Plac Other: 4 \( \text{N} \) Injury at Work? 1 \( \text{Yes} \) 2 \( \text{L} \)	Nursing Hom	24a. Was auto perf 1 yes (Check only ne 5 HRs. Res. 88. Describe	s an 24b psy 25 normed? 2 to No 2000 psy 25 no 2000	o. Were aut prior to c death? 1 Yes	opsy findings available ompletion of cause of 2  No	
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	Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pendii  2 Accident invest  3 Suicide 6 Could deterr  29a. Certiffier 1 Certifyi	Hospital: 1 [28a. Dat (Moggation not be inined] 28e. Plained	te of Injury onth, Day, Year) ce of Injury - At Iding, etc. (Spe	28b. Time of Injury home, farm, so	ent 3 DOA of 28c M treet, factory, o	26. Plac Other: 4 North	Nursing Hom 2 No 2 and place, a	24a. Was auto perf 1 yes (Check only ne 5 Hes Res 28d. Describe	s an ppsy promed? 2 No one) sidence 6 Chow injury occidence (Street and Nurwin, State)	b. Were autroprior to codeath?  1 Yes  Other (Specurred)	opsy findings available ompletion of cause of 2 No sify)  rai Route Number,	
	Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendii 2 Accident 3 Suicide 6 Could 4 Homicide  29a. Certifier (Check only one)	Hospital: 1 [28a. Dat (Mc) gation not be anined 28e. Planined 28e. Planined 28e. Planined 28e. Planined 28e. Planined and maintenance 28e. Planined 28e. Pla	te of Injury onth, Day, Year) ce of Injury - At Iding, etc. (Spe	28b. Time of Injury home, farm, so	ent 3 DOA of 28c M 28c treet, factory, o	26. Plac Other: 4 □ N Injury at Work? 1 □ Yes 2 □ ffice the time, date a my opinion, de	No 2 and place, a eath occurre	24a. Was auto perf 1 □ Yes (Check only ne 5 ♣ Res 3d. Describe 8f. Location City or To	s an ppsy cormed? 2 No one)  sidence 6 Chow injury occurred and Nur win, State)  e cause(s) and c, date and place	D. Were autoprior to coleath; 1 □ Yes  Other (Specurred)  manner as e, and due	opsy findings available ompletion of cause of 2 \( \subseteq No \)  If the control of cause of 2 \( \subseteq No \)  If the control of cause of 2 \( \subseteq No \)  If the control of cause of	
	o Be	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendii 2 Accident 3 Suicide 6 Could 4 Homicide  29a. Certifier 1 Check only 2 Medica	Hospital: 1 [28a. Dat (Mc) gation not be anined 28e. Planined 28e. Planined 28e. Planined 28e. Planined 28e. Planined and maintenance 28e. Planined 28e. Pla	te of Injury onth, Day, Year) ce of Injury - At Iding, etc. (Spe he best of my ke basis of exam	28b. Time of Injury home, farm, so	ent 3 DOA of 28c M 28c treet, factory, o	26. Plac Other: 4 North	No 2 and place, a eath occurre	24a. Was auto perf 1 □ Yes (Check only ne 5 ♣ Res 3d. Describe 8f. Location City or To	s an ppsy promed? 2 No one) sidence 6 Chow injury occidence (Street and Nurwin, State)	D. Were autoprior to coleath; 1 □ Yes  Other (Specurred)  manner as e, and due	opsy findings available ompletion of cause of 2 \( \subseteq No \)  If the control of cause of 2 \( \subseteq No \)  If the control of cause of 2 \( \subseteq No \)  If the control of cause of	
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State

Registrar

31. Date filed (Month, Day, Year)

JUN 29 2009 parks.

9-05278	Please Type or Print in Black Indelible Ink. Ensure All Copie								
heryl Brice Moore	Otato of Marylana / Dopartmont of Front and Marylana	ygiene 2009 2243							
	Registrar Gertificate of Death	rteg. No.							
Physician. Medical Examine		2. Date of Death Month Light 5 2009  3. Time of Death 0301 hrs							
)	CHERYL BRICE MOORE  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	July 5, 2009							
	722 Anchor Chain Road Ocean City	Worcester							
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs								
Director	222-46-0652 <sub>1 M 2</sub> X F 47 Yrs. Months Days Hours Min	3-30-1962   Country) DELAWARE							
	Usual Residence of Decedent								
any	10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits							
show	MARYLAND WORCESTER OCEAN CITY	1 X Yes 2 No							
the Maryland as or 28a-f sh	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?							
death with the Maryland reitens 23a or 28a-f show any must be notified at once,	722 ANCHOR CHAIN RD, HARBOR LIGHTS 21842	US							
ms 22	11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Signature of Marian)  14. Was Decedent of Hispanic Origin? (Signature of Hispanic Origin?) (Signature of Hispanic Origin?)								
r death with or items 2:	1 Never Married 2 Married 1 Yes 2 X No								
	3 Wildowed 4 X Divorced if the state of Dates:	Specify: WHITE work done 16b. Kind of Business/Industry							
hour hour Exan	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)								
36 nin 72 than "	2 OFFICE MANAGER	RESTAURANT							
15-0036 Highene Hygiene do other than "natural" the Medical Examine	17. Father's Name (First, Middle, Last)  18. Mother's Name	e (First, Middle, Maiden Surname)							
		MCWHORTER							
21 hould I hould I is mar itic ev		Rural Route Number, City or Town, State, Zip Code)							
	MAXINE UNGERBUEHLER/MOTHER 34429 RETZ LANE, LEWE								
ore, MC ss Land 2 s of Health at If item 27	20a. Method of Disposition    X Burial   2   Cremation   3   Removal from State   CHRESTON CHURCH CHOICE   CHRESTON CHURCH CHOICE   CHRESTON CHURCH CHOICE   CHRESTON CHURCH CHOICE   CHRESTON CHURCH CHOICE   CHRESTON CHURCH CHOICE   CHRESTON CHURCH CHOICE   CHRESTON CHURCH CHOICE   CHRESTON CHURCH CHOICE   CHRESTON CHURCH CHOICE   CHRESTON CHURCH CHOICE   CHRESTON CHOICE   CHRESTON CHURCH CHOICE   CHRESTON CHRISTON CHOICE   CHRESTON CHOICE   CHRESTON CHOICE   CHRESTON CHOICE   CHRESTON CHOICE   CHRESTON CHOICE   CHRESTON CHRESTON CHOICE   CHRESTON CHRESTON CHRESTON CHOICE   CHRESTON	Date 20c. Location - City or Town, State							
mo Page nent o ant:	4 Donation 5 Other Specify: MILFORD CEMETERY 7-1	0-09 MILFORD, DELAWARE							
Baltimore, permit. Pages I at Department of He Important: If ite injury or other tr	21. Signature of Fund at Service License 22 Name and Address of Facility MELSON FUNERAL SER	VICES, LTD							
	143 THATCHER STREET	FRANKFORD, DE. 19945							
Physician /Medical	23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	Between Onset and							
caminer	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	Death							
	but to (a) as a solitoryatives of).								
5	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):								
ted nsit	(Disease or injury that initiated exemts resulting in death). Last Due to (or as a consequence of):								
ted ansit	events resulting in death) Last Due to (or as a consequence or):								
ox 68760, and certificate be executed attending physician and or use as the burial - transit	X AMENDED 23a, 27, 28a-f, per ME g893, 7/2 #27 & 28d, per ME g894 8/14/	3/09 TT							
). Box 68760, the death certificate be by the attending physici ched for use as the burith but it is a sufficient when the control of the characteristics.	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery							
S87 rriffce ling p	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant in the								
Sox (leath ce attence for use	1 Yes 2 No 9 ✓ Unknown 1 Unknown 1 Unknown 2 Unknown 2 Unknown 3 Unknown 2 Unknown 3 Unknown 2 Unknown 3								
D. B.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?							
P.O. E s that the d		1 Yes 2 No 3 Probably 4 Unknown							
ords, P w requires t us been sign should be		24a. Was an   24b. Were autopsy findings available							
SOFC law re has be 2 sho		autopsy prior to completion of cause of death?							
ian: The law requires certificate has been signered by page 2 should be		1 Yes 2 No 1 Yes 2 No							
tal	25. Was case referred to medical 25.Place of Death (Check examiner? Other: Othe								
fV; Physi er this	27 Manager of Death 29a Date of Lating 29b Time of Lating at Work?	ng Home 5 Residence 6 Other: Scene  28d. Describe how injury occurred subject							
n of oding Plus After to funera	(Month, Day, Year)  Natural 5 Pending Fd 7/5/00 Fd 2.53 am 1 Yes 2X No	unk ingested prescribed							
SiO Atten r deat ector by th	Pending Investigation Investigation Relation Investigation Investigation Relation Investigation Relation Investigation Relation Relation Services Relation R	medication with alcohol 28f Location (Street and Number of Rural Route Number, City.							
Division ospital or Attending spital or Attending hours after death.  neral Director: After filled in by the fune	3 Suicide Could not be determined (Specify)  Note: The suicide determined (Specify)	28f. Location (Street and Number or Rural Route Number, City, Anchor Chain Rd							
Lospii 4 hour funer									
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burning and the certification.	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	at the time, date and place, and due to the cause(s)							
F.W.F.S	29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)							
	auc) O.C.M.E.	July 6, 2009							
OK 1.	30. Name and address of person who completed cause of death (Item 23a)								
BA2 pending	Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201								
Star	a 31. Date filed (Month, Day, Year)  32. Registrar's Signature  33. Registrar's Signature								
Registra									
DHMH 17 Rev 1/200									

DHMH 17 Rev 1/2001 OCME 2006

Maryland 21215-0036 Baltimore,

Box 68760,

Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2009 4:18 P M Philip Joseph Martini June 22 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □XM 2 □ F Director 123-14-5003 2/10/1925 Usual Residence of Decedent 10b. County VOlusia filed within 72 hours after death with the Maryland 10c. City, Town or Location
New Smyrna Beach 10d. Inside City Limits 10a. State 28a-f show event, the Medical Examiner must be notified at 1 ¥Yes 2 □ No Director Anne Arundel Annapolis 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 154 Marina Bay Dr. 23a or 32169 USA 4 Southeate 21401 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ∏Yes 2 No Yes, Give WWII ō 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No ģ Specify: White 3 Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Manufacturers' Representative Self-Employed permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked ofth any lighty or other traumatic event sonce. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph A. Martini ဂ္ Margaret Curtin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1351 Mover Rd, Annapolis, MD 21403 Philip Joseph Martini Jr./Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, MD Hillcrest Memorial Gardens 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home Myelin T. Klobert 147 Duke of Gloucester St, Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Intracerebra **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leaf in grant cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to lor as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) ☐Yes 2 ☐ No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 24 hours after death Funeral Director: 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Medical 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D46052 6/22/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Siveral Bech, MD 2001 Medical Parkway, annapolis, HD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Beneva A. park

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #10a-f Per Infate893Mal/24/109DEBartment of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 26. Day 2009 Year 11:30 Pm Paul Alex McConkey 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Clinton Southern Maryland Hospital Center If Under 1 Year Hours Min. 8. Date of Birth Boay, Feb 25, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Washington,DC 1**x** M 2 □ F Months 220-38-4132 68 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2X☐ No Upper Marlboro Prince George's

10f. Zip Code

1 ☐ Yes 2 ☐ No

16a. Decedent's Usual Occupation

Electrician

20772

(Give kind of work done during most of working life. DO NOT use retired)

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify.

10g. Citizen of What Country?

14. Race - American Indian,

Black, White, etc.

Specify: White

16b. Kind of Business/Industry

Construction

U.S.A.

18. Mother's Name (First, Middle, Maiden Surname)

Mary Glover

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

**Funeral** Director 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Exercites to the retiffical at Director Funeral Baltimore, Maryland 21215-0036 b Completed Be

**Physician** 

/Medical

**Examiner** 

1 - State Registrar

10a. State

Md.

11. Marital Status

10e, Street and Number

6306 Buttercup Lane

Unavailable 19a. Informant's Name/Relationship (Type. Print)

15. Decedent's Education (Specify only highest grade completed)

JUN 29 2009

1 Never Married 2 Married

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

12. Was Decedent Ever in U.S. Armed Forces? 1√Yes 2 □ No IfYes, Give 1958–62 Year or Dates:

College (1-4or 5+)

**Physician** /Medical Examiner

Examiner physician and the burial-transit Physician/Medical attending ph cate has been signed by the page 2 should be detached <u>ک</u> Completed After this certificate has funeral director, Be Certification: To within 24 hours after death.

To the Funeral Director: Air completely filled in by the fu death.

The law requires that the death certificate be executed

Box 68760.

P.0.

Division of Vital Records,

Hospital or Attending Physician;

6306 Buttercup Lane, Upper Marlboro, Md. 20772 Nancy McConkey(Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cheltenham Veterans Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 7/10/2009 Cheltenham, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, INC 6633 Old Alexandria Ferry Rd. Clinton, Md 20735 23a. Part1. Enter the disease, or complications tha d the death. Do not enter the mode of dying diac or respiratory agrest, shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Liseane or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? **significant conditions** con<u>tribut</u>ing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autops 1 □ Yes 26. Place of Death (Check only one 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

State of Maryland / Department of Health and Mental Hygiene 🤉 For State Registra Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death **Physician** Clarence Roscoe Mullins June 18, 2009 6:29A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Shady Grove Hospital Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Days Hours Year) 1 XM 2 □ F 1925 West Virginia Director 184-14-0389 83 August 10, Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show 1 XYes 2 □ No Director MD Montgomery Germantown 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 20874 19054 Cherry Bend Drive United States Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examination. Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No \$ Specify: 3 Widowed 4 Divorced Black WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Trucking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last Be Nannie Belle Logan Edward Roscoe Mullens 2 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Jefferson/Daughter 13017 Wisteria Drive, Germantown, MD 20874 Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Fort Lincoln Crematory06/26/2009 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simple Tribute 21. Signature of Furneral Service Licensee M01043 20850 1040 Rockville Pike, Rockville, MD 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Pulmonary Embolus

The pulmonary Embolus

The pulmonary Embolus or as a consequence of the condition of the condi Approximate Interval Between set and Death Minutes **Physician** /Medical Due to (or as a consequence of): Examiner Months Deep Venous Thrombosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Lung Cancer Years burial-tran Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. physician Physician/Medical the attending pl 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy 1 □Yes 2 X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ij Certification: To 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred After 1 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: # 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical within 24 ho

To the Fune

completely f and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 D62553 2009 June 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patsy M. McNeil, M.D., 9901 Medical Center Drive, Rockville, MD 31. Date filed (Month, Day, Year) Registrar's Signature State JUN 29 2009 Registrar

Asad Nabatzahi 09-05001

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State of Maryland / Department of Health and Mental Hygiene
Otate of Maryland / Bobaranon of Treatment

INK UNK	1- For State		nent of Health and Mental H cate of Death	ygiene Reg. No.	10 221.3
Physician/	Registrar  1. Decedent's Name (First, Middle,Las	the second control of the second		2. Date of Death  Month Day Year  June 24, 2009	3. Time of Death 2100 hrs
Medical Examiner	4a. Facility Name (if not institution, give		4b. City, Town, or Location of Death	4c. County of Deat	h
		Legion Bridge on MD side	The second second second second	Montgomery  s. 8. Date of Birth(MM/DD/YYYY) 9. Bi	rthplace (State or
Funeral Director	5. Social Security Number 6. S 216-67-7777 12	ex 7. Age (In yrs. last b	yrs. If Under 1 Year If Under 24Hr Months Days Hours Mir	Forei	gn ountry) TRAN
any	Usual Residence of Decedent  10a. State  10b. County	10c. City, Tov	wn or Location		10d. Inside City Limits
≥ 1		edoun	Leesburg	10g. Citizen of What Co	1 X Yes 2 No
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with the ms 23a be noti	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? ( S If Yes, specify Cuban, Mexican, Puert	, , , , , , , , , , , , , , , , , , , ,	erican Indian, Black,
er death with , or items 23 r must be no Funeral		1 Yes 2 No	1 Yes 2 X No specify:		Rite
ours aft atural" samine	15. Decedent's Education (Specify of	f or Dates:	Sa. Decedent's Usual Occupation (Give kind of during most of working life, DO NOT use re	work done 16b. Kind of Business tired)	s/Industry
Pages 1 and 2 should be filed within 72 hours after death with the Maryland men of Health and Mental Hygiene.  To the Completed Formula Hygiene or other transmitter event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	Elementary/Secondary (0-12)	College (1-4 or 5+)	Student	Educa	tion
Baltimore, MD 21215-0036 pe mit. Pages I and 2 should be filed within 72 Department of Heath and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical				ne (First, Middle, Maiden Surname)	
2121: tould be fil d Mental B is marked tic event, To Be	19a. Informant's Name/Relationship	Type, Print)	19b. Mailing Address (Street and Number of	Rural Route Number, City or Town, Sta	ite, Zip Code)
MD 2 short alth and 2 is m 27 is reumatic	MAHDIA NABAT	ZAHI SISTER	18803 Kipheart Di	r. Lees burg VA  Date 200-Coation - City	20176
Ore, ges l an t of Hea : If iter	20a. Method of Disposition  1 Burial 2 Cremation 3	Removal from State crea	matory or other place)	129/09 Alexan	Isia VA.
Baltimore, be mit. Pages 1 a Department of He Important: If ite	4 Donation 5 Other Special 21. Signature of Funeral Service Lice		22. Name and Address of Facility	den Muslim F	uneral Jes
	A hillip Bu	U &	o not enter the mode of dying, such a cardiac	or respiratory arrest, shock, or heart	Approximate Interval
Physician /Medical	failure. List only one cause on	each line. a. Drowning	o not onto. The most of symphoton	•	Between Onset and Death
xaminer	or condition resulting in death)	Due to (or as a consequence of):			
je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of):			
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60, ate be execu hysician and te burial - tra		23c. If yes, outcome of pregna		23d. Date of deliv	
Box 6876 e death certificate the attending phy ed for use as the busician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time of deat	2 Fetal death 3 Ectopic prec  b 5 Other (Specify)	nancy Month	Day Year
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That s that s that s detr	2	s contributing to death but not resi	utting in the underlying cause given in tarti.	1 Yes 2 No 3	
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Reco				performed? deat	
Vital Rec ysician: The his certificate director, page	examiner?	Hospital: 1 Inpatient 2 E	26.Place of Death (Che R/Outpatient 3 DOA Other,4 Nu	rsing Home 5 Residence 6 🗸 C	ther: Scene
Division of Vital Records, ha or Attending Physician: The law requirants after death birctoor: After this certificate has been sited in by the funeral director, page 2 should be attituded.	27 Manner of Death	(Month Day Veer)	28b. Time of Injury 28c. Injury at Work?  FOUND: 1 Yes 2 ✔ No.	28d. Describe how injury occurred Subject drowned	
Division os spital or Attending tours after death neral Director: After filled in by the function:	Natural 5 Pending 2 Accident Investig	Jun 24, 2009	FOUND: 1 Yes 2 ✓ No 1930 hrs 1 Yes 2 ✓ No ne, farm, street, factory, office building, etc.	28f. Location (Street and Number o	r Rural Route Number, City
Divi		ned (Specify) River		or Town, State) 400 m N American Legion Bridg	
Divis  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b		sician: To the best of my knowledge ner:On the basis of examination and	e, death occurred at the time, date and place, d/or investigation, in my opinion, death occurr	and due to the cause(s) and manner as ed at the time, date and place, and due	stated. to the cause(s)
To C com	(Check only 1 Certifying Physical Control Cont	and manner stated.	29c. License number		(Month, Day, Year)
	Pote Care	- Hollet no	O.C.M.E.	June 25, 200	9
10/	30. Name and address of person was Patricia Aronica-Pollak	no completed cause of death (Item 2 MD. Assistant Medical E		nore, MD 21201	
Star	01.7.1.61.101.2.5.143	32. Registrar's Signatur			

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 26 2009 06 4:15am <u>Linda S. Pellish</u> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rockville Suburban Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yea, 04/20/1937 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2√2 F 72 075-30-8372 Director New York Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Marylan 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. Medical Examination to substitute and once. tX∏Yes 2 □ No Director Rockville MD Montgomery 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code 11916 Renwood Lane 20852 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Government-Elementary/Secondary (0-12) College (1-4or 5+) Architecture 5+ Architect 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Max Straus Elise Lezinsky ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) David Pellish, husband 11916 Renwood Lane, Rockville, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Memorial Grdns. 06-28-09 Olney, MD 22. Name and Address of Facility Edward Sagel Funeral Direction 21. Signature of Juneral Sen 1091 Rockville Pike, Rockville, MD 20852 Approximate Interval Between Onset and Death 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Multiple Myeloma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. and burial-trar Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for 1 in the past 12 months? 1 ☐ Yes 2 🎇 No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown ģ signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed page 2 should been s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐Yes 2 ☐ No 24a. Was an has autopsy perform certificate 1 □Yes 2X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 🕅 Natural 2 🗋 Accident 5 Pending investigation in 24 hours after uc.....the Funeral Director: Af 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10 06-27-09 D26259 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ava Kaufman 8218 Wisconsin Ave. Bethesda, MD

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JUN 29 2009

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

**Division of Vital** 

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82. Registrar's Signature

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	Examin				ve street and numbe			4b. City, Town, o	or Location	of Death			. County of Dea		
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036	72 hours after death with the Maryland natural", or items 23a or 28a-f show Usal Evanieser rust be notified at	δ	1 ☐ Never Marri	ied 2□ Married 4□ Moivorced	If Yes, Give Year or Dates			1 ☐ Yes 2X No	Specify	<b>/:</b>			Specify:	hite	
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Michal Event incrinal be notified at once.		1XX Burial 2		Removal from Stat	e c	emetery, cr	ematory or other pla eph Cemet	i .	6/27/	ี วกกจ	COL	ipon, PA	1	
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Division of Vital Records,	or Att	Certification: To	3 ☐ Suicide 4 ☐ Homicide	determine	ZOE. Flace UI	Injury - At he etc. (Speci	ome, farm, : fy)	street, factory, office			28f. Location City or T			Rural Route Number,	
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DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Vear Rebibo **Physician** Solange 06 28 2009 2:25 A /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Montgomery Rockville 11410 Strand Drive Apt.312 9. Birthplace (State or Foreign Country) Casablanca If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 92 Months Hours Min. 1 □ M 2**X**□ F 12-25-1916 229-88-5527 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show the Medical Exp. ther must be notified at 1XYes 2 □ No Director MD Montgomery Rockville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 20852 USA 11410 Strand Drive Apt. 312 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or items 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 📉 No Specify: Specify: þ 3X Widowed 4 ☐ Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Clothing 2 Seamstress or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Esther "unknown" Aron Sabah ္ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health an Important: If Item 27 is n any injury or other traun 11410 Strand Drive Apt 102, Rockville, MD 20852 Samy Ymar / son-in-law 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Mt. Lebanon Cemetery 06-28-2009 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Adelphi, MD 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc 21. Signature of Funeral Service Licensee Edward Sagel 1091 Rockville Pike Rockville, MD 20852 M00910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of heart failure **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque Examiner certificate be executed Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2 No signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 🗆 Yes certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 Wo 1 ☐ Yes 2 ☐ No 1 □Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) Hospital: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Natural 5 Pending investigation 1 TYes 2 DNo 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical

Division of Vital Records, Hospital or Attending Physician: 7 24 hours after death. Funeral Director; After this certifica completely filled in by the 24 hours a within 2. the 9

> State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only one)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D42518 JUNE 28,2009 EVILLE PIEG #401 ROCKUILLE EVILLE PIEG #401 MD20852

29d. Date signed (Month, Day, Year)

120C

2009 22440

		1- For State Registrar			Certific	cate of	Death			F	teg. No.			
Physicia	an/	1. Decedent's Name (First, Middle,Last)  2. Date of Death  Septect H. Ramey, Jr.  2. Date of Death  John Day  Year  O938 hrs												
ledical Exami	ner	Kenneth H. Ramey,	Jr.							July 6, 20	09			38 nrs
		4a. Facility Name (if not institutio Washington County H	-	umber)		41	. City, Town, o Hagerstow		of Death			ounty of C shingto		
Funeral		5. Social Security Number	6. Sex	7. Age (Ir	yrs. last bi	rthday)	If Under 1 Ye			8. Date of B	rth (MM/DD	(YYYY)	9. Birthplace	(State or Foreign
Director		213-25-4901	1 <b>X</b> M 2 F		27	Yrs.	Months Da	ys Hours	Min.	April	13, 19	82	Country) Florid	a
	}	Usual Residence of Decedent								- 17	207 25			
any	ı	10a. State 10b. County		100	. City, Tow	n or Locatio	n						10d. lr	nside City Limits
1	٦	Maryland 1	Montgomery			Olney							1	Yes 2 X No
S S In Maryland or 28a-f show fied at once	윉	10e. Street and Number					10f. Zip Code				10g. Citizer	of What	t Country?	
rith the Maryland  23a or 28a-f sho notified at once	Director	3440 Queensbor	ough Drive				20832				USA			
with th		11. Marital Status	12. Was De		r in U.S.		Decedent of H				0- 14		American Ind	lian, Black,
leath r iten	Funeral	1 X Never Married 2 M	arried Armed F		No	If Ye	s, specify Cuba	an, Mexican,	, Puerto Ri	can, etc.)		White,	etc.	
after o	by F	3 Widowed 4 Div	orced If Yes, Give Ye			1 7	res 2 <sup>X</sup> N	o specify:			Sp	oecify <b>Wh</b>	ite	
ours a		15. Decedent's Education (Spe	cify only highest gra	de comple	ted) 16a		s Usual Occup st of working lif				16b. Kind	d of Busir	ness/Industry	'
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she omatic event, the Medical Examiner must be notified at once	Completed	Elementary/Secondary (0-12)	College (	1-4 or 5+)			nstructi			-,	Co	nstru	ction	
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	E	17. Father's Name (First, Middle,	Last					I 19 Mother	's Name /F	irst, Middle,	Maiden Su	irname)		
21215-0 21215-0 201d be filed w 1 Mental Hygic in marked other ic event, the A	Be C	Kenneth H. Rame						18.Motrie		e Lee C				
212 212 213 214 be Menta mark c even		19a. Informant's Name/Relations			1	9b. Mailing	Address (Stre	eet and Nun					State, Zip C	ode)
imore, MD 2121 Pages I and 2 should be fi nent of Health and Mental lant: If item 27 is marked or other traumatic event,		Kenneth H. Rame			- 1	16 Mc	Glynn La	ne. Bur	nker H	ill. WV	25413			
and and lealt		20a. Method of Disposition	···			of Disposit	ion (Name of c	emetery,	1	Date			City or Town,	State
nore ges l it of l :: If i		1 X Burial 2 Cremation	n 3 Removal f	rom State	Gate o	atory or othe of Heav	erplace) r <b>en Cemet</b>	ery		ly 11,	G. 1			· · ·
Itingit. Partition of the partition of t		4 Donation 5 Other Si 21. Signature of Funeral Service				22 Na	me and Addre	ss of Facility		009	Sil	ver S	pring,	MD
Baltimore permit. Pages I Department of F Important: If i		21. Signative of Funcial Screece				Fra	ncis J. Univers	Collins	Fune:	ral Hom	e Inc.	na M	ED 20001	
Physician		23a. Part I. Enter the disease, or		caused the	death. Do								t App	roximate Interval
/Medical	8 8	failure. List only one cause		00 07	rhwth	mia							Bet	ween Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as			шта								
-	.	Sequentially list conditions,	b. Dilate	d lef	t ven	itricu	lar hy	ertro	phy					
	<u>.</u>	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as	a consequ	ence of):									
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8760, tiffcate being physic as the bur	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes			У						Date of d		V
ଅନ୍ତ 🛱 ଭିଷା	ä	past 12 months?	I Live	birth nant at tim		2 Feta	al death 3 er (Specify)	Ectopi	c pregnanc	СУ	"	Month	Day	Year
Box 687  The death certification is the attending properties of the action of the acti	Physicia	1 Yes 2 No 9 Un	known	nown		J Oth	er (Specify)							
that the ned by the detached		Part II. Other significant condit	_				nderlying cause	given in Pa	art I.	23e. Did	tobacco us	e contrib	ute to the ca	use of death?
ords, P.O. w requires that the state of the	Completed by	Acute and	chronic	alcoh	ol us	e				1 Y	es 2	No 3	Probably	4 <b>U</b> nknown
Division of Vital Records, tat or Attending Physician: The law requirers after death.  al Director: After this certificate has been siled in by the funeral director, page 2 should be	ete									24a. Wa	s an opsy			findings available tion of cause of
tal Recor	E G									per	formed?	de	eath? ✔ Yes	2 No
- R		25. Was case referred to medica					26.Pla	ce of Death	(Check or		2	1 ' [	V, 100	
Vital Rec hysician: The this certificate al director, page	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient	2 🗸 ER/	Outpatient	3 DOA	Other <sub>4</sub>	Nursing	Home 5	Residence	ce 6	Other:	
n of Ning Ph	-1	27. Manner of Death	28a. Dat	e of Injury th, Day,Year		. Time of In	jury 28c. ir	jury at Worl	k? 2	8d. Describ	e how injury	y occurre	d	
ion tendir eath. tor: A	ē	1 X Natural 5 Pen	ding	in, Day, roar			1	Yes 2	No					
VISI or Att fler de frect in by	ij		stigation 28e. Pla	ce of Injury	- At home,	farm, stree	t, factory, office	e building, e	tc. 2	28f. Location or Town		Number	r or Rural Ro	ute Number, City
Divis pital or At ours after d neral Direct	Certification:		rmined (Specify	')						OI TOWN,	State)			
Division of Vital Records, P.O. Box 6: To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use a	Medical (	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the be											se(s)
1 .	Med	29b. Signature and title of certific	and manner	stated.				nse number					d (Month, Da	
HPEN	>	(10.00	N/a	00.	111		0.0	C.M.E.			July	7, 2009	€	
'		30. Name and address of persor	who completed cal	use of dead	h (Item 23a	1)								
		·	sistant Medica				treet, Baltii	nore, ME	21201					
S	ate	31. Date filed (Mosth, Day (Sar)	2000 75	Registrar's	Signature	far	1							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 22661

Terry Eugene Ro		on S	tate of M	faryland /		tment of		and	Menta	al Hyg				109	2244
	F	legistrar 1. Decedent's Name (First, Mid	dia Last\		Certi	incate of	Deam	-		2.	Date of De	Reg. No ath		3.	Time of Death
Physicia Mr *al Examir		Terry Eugene		con						1	Month July 3, 20	Day	Year		1221 hrs
di Exami		4a. Facility Name (if not institut				- 4	b. City, To	wn, or Lo	ocation of				c. County of D	eath	
		Anne Arundel Medic		·			Annapo	olis					Anne Arun		
Funeral		5. Social Security Number	6. Sex	7. Age	(In yrs. las	et birthday)	If Under	_	If Under		8. Date of E	irth(MN	//DD/YYYY) 9	. Birthpl Countr	ace (State or Foreign
Director	1	214-84-5385	1 X M	2 F	46	Yrs	Months	Days	Hours	Min.	Aug.	3,	1962		ryland
	ŀ	Usual Residence of Decedent													
any	Ī	10a. State 10b. Count				own or Locati									Yes 2 X No
show	5	MD Ann	e Arun	del	S	everna									
Aaryls Aaryls 1840	Director	10e. Street and Number					10f. Zip C					10g. C	itizen of What		f
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5-0036 led within 72 hours after death with the Maryland it giene.  other than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once.	Funeral	11. Marital Status		Was Decedent I Armed Forces?	Ever in U.S	6. 13. Wa	s Deceden es, specify	t of Hisp Cuban,	anic Origii Mexican, I	n? ( Spe Puerto R	cify Yes or I ican, etc.)	NO-	14. Race - P		n Indian, Black,
or ite	띮	1 Never Married 2 X	1	Yes 2	X No		Yes 2	No.	enecifu:				Specify: W	hita	
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5-0036 led within 7 Hygiene. other than the Medica	Completed	17. Father's Name (First, Midd	le, Last)					1		,		e, Maide	en Surname)		
215 be file mtal H rked c	Be	Richard Robi								an P					
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ore, slar of Hee If ite		20a. Method of Disposition  1 Burial 2 X Cremat	on 3 R	emoval from Sta	te C	rematory or of	ther place)			Jul	Ly 10,		Glen Bu		
altimore, rmit. Pages 1 ar spartment of He prortant: If ite		4 Donation 5 Other	Specify:		Atl	Lantic					009	Ш.,	GIEII DO	TILL	e, rid
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygione. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		21. Signature of Funeral Servi	ce Licensee	//		Pa.	rrance France GOV	Address	Sons	, P.	A. S	ever	na Par	ķ Fi	meral Home 1D 21146
	1	23a. Part I. Enter the disease,	or complication	ons that caused	the death.	Do not enter	the mode o	• K1 f dying, s	such as ca	e HW ardiac or	y . So respiratory	arrest, s	na Par shock, or heart	K, N	Approximate Interval
Physician 'Medical	1	failure. List only one cau	se on each lir	ne.											Between Onset and Death
.xaminer		Immediate Cause (Final disea or condition resulting in death	se a. A Due t	therosc	Lerot equence of	ic car	птома	scu	Lai u	1364	isc				
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	ner	if any, leading to immediate cause. Enter Underlying Cau		to (or as a conse	equence of	F):									
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of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and timeral director, page 2 should be detached for use as the burial - transit	a)	IF FEMALE:		3c. If yes, outcor	me of preg			2			201		23d. Date of d Month	elivery Da	y Year
6876( certificate nding phy	sician/M	23b. Was decedent pregnant i past 12 months?	1	Live birth Pregnant at	time of de	-	etal death Other (Spec	3 [	Ectopic	c pregnai	ПСУ	- 1	WOTH	Do	.,
Box e death or the attended for us	ysic	1 Yes 2 No 9	Unknown g			3 (	Julei (Opci								
D. E it the o	Phy	Part II. Other significant cor	ditions con	tributing to deat	h but not r	esulting in the	underlying	cause g	given in Pa	art I.					ne cause of death?
P. (P. res that signed be det	d by	Torso Inju	ries								1	Yes			ably 4 V Unknown
rds requi been hould	Completed											utopsy	pr	ior to co	opsy findings available empletion of cause of
SCO ie law te has ge 2 s	du					-						erforme es 2		eath?	2 No
l R	ပို	25. Was case referred to med	lical					26.Place	e of Death	(Check	only one)				
/ita ysicia his ce direct	o B	examiner? 1 ✓ Yes 2 No	Hosp	ital: 1 Inpati	ent 2 🗸	ER/Outpatie	nt 3 D	OA	Other <sub>4</sub>	Nursin	g Home 5		sidence 6	Other:	
Division of Vital Records, P.O. rate or Attending Physician: The law requires that the rate death.  The price of the this certificate has been signed by led in by the funeral director, page 2 should be detach	⊢	27. Manner of Death		28a. Date of Inj (Month, Day.)	ury Year)	28b. Time o	f Injury		ıry at Work				injury occurre m bicy		
	흝		ending rvestigation	7/3/09		11:08			Yes 2						
ivisi I or At after d Direct	<u>i</u> ë	3 Suicide 6 (	ould not be	28e. Place of I	njury - At h roadw	nome, farm, sti	reet, factory	, office t	building, e	etc.	28f. Locati or Tov	on (Stre	eBay Fr	r or Rur <b>ont</b>	al Route Number, City $\mathbf{Rd}$
Di Hospital 24 hours ? Funeral !	Certification:	4 Homicide	etermined	(Specify)											
Divisior  To the Hospital or Attend within 24 hours after To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifyin	g Physician: Examiner: On	To the best of n	ny knowled amination a	ige, death occ and/or investic	curred at the pation, in m	e time, d y opinior	late and pl n, death o	lace, and ccurred a	I due to the at the time, o	cause(s date and	s) and manner d place, and di	as state Je to the	cause(s)
To the within To the comple	Medical	29b. Signature and title of ce	and	manner stated					se number		-		9d. Date signe		
	2	290. Signature and title of ce	SC 1	/ ./	. 4		120		M.E.				July 4, 200		
		+ankly	Buth	cell, ri	dooth (the	n 23a)									
AILD'		30. Name and address of pe Pamela E. Southal		pleted cause of ssistant Med			I11 Penr	Stree	et, Baltir	nore, N	MD 2120	1			
SP C	tate		ear)	32. Registr		ture									<del></del>
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Physicia	
/Medic Examin	
LAUIIIII	
Funeral	

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Evaninar must be notified at once.

Baltimore, Maryland 21215-0036

Physician \* /Medical Examiner

ne Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours after death.

In 24 hours after death.

The Funeral Director: After this certificate has been signed by the attending physician and pletely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

KB To withing withing the sound of the sound	30 Name and address of person who completed cause of death (It
State Registrar	31. Date filed (Month Per Year) 2009 32. Jegistrar's Sig
HMH 17 Rev 1/2001	

1 - State Registrar	Ce	ertificate of D	eath		Reg. No.	LUA	4	46
1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	Day	Year	3. Time of I	
Daniel L. Spelle		T		June	28,	2009	8:15	A M
4a. Facility Name (If not institution, give street and n	umber)	4b. City, Town, or L	ocation of Death Lerick	1	4c. Cou	inty of Death	erick	
Northampton Manor  5. Social Security Number 6. Sex	7. Age (In yrs. last birthda)		If Under 24 Hrs.	8. Date of Birt	th	9. Birth	place (State or	r Foreiar
578-60-7262  Usual Residence of Decedent	62 Yrs.	Months Days	Hours Min.	(Month, Da	y, Year)	Cou	ntry) hington	_
10a. State 10b. County	10c. City, Town or L	Location		<del>`</del>			10d. Inside Cit	y Limits
Maryland Frederick	Fr	rederick					1 ☐ Yes	X No
10e. Street and Number 5236 Jefferson Pike		10f. Zip Code <b>21703</b>			10g. Citizen United		-	
11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was December 4 Married 1 Yes, C	2 🔼 No iive	B. Was Decedent of His If Yes, specify Cuban, 1 ☐ Yes 2 🛣 No	panic Origin? (S Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)		Race - Amer Black, White, ecify:		
15. Decedent's Education (Specify only highest grade completed		cedent's Usual Occupat		kina i	16b. Kind o	f Business/II	ndustry	
Elementary/Secondary (0-12) College	(1-4or 5+)	. DO NOT use retired)	ing most or mon	9	Res	identi	a1	
12	Pa	ainter	D. Madharia Nam	ne (First, Middle,				
17. Father's Name (First, Middle, Last)  Morris Speller		1		Waldron		name)		
19a. Informant's Name/Relationship (Type. Print)		iling Address (Street an			-			
I del los de la la la la la la la la la la la la la		20 Horsesho		, Freder		on - City or T		
20a. Method of Disposition  1 □ Burial 2 ▼Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)		position (Name of ematory or other place) r Crematory		9/2009			Marylar	nd
21. Signature of Funeral Service Licensee	//	22. Name and Address		Staufferike, Fre				
23 Part1. Enter the theuse or complications that show, or heart failure. List only one cause on Immeriate Cause (Final disease or condition	caus of the death. Do not e each line.						Approximate Interval Betwoonset and D	ween Death
resulting in death) Due to	(or as a consequence of):						HON174	+5
cause. Enter Underlying	(or as a consequence of):					146		
Cause (Disease or injury that initiated events resulting in death) Last Due to	o (or as a consequence of):						· -	
d								
IF FEMALE: 23c, If yes, o	utcome of pregnancy				234	. Date of deli	MARY.	
in the past 12 months?	e birth 2 🗆 Fetal death 3 gnant at time of death 5	B ☐ Ectopic pregnancy D ☐ Other (specify)			200	Month		⁄ear
Part II. Other significant conditions contributing to	death but not resulting in the	underlying cause given	in Part I.	23e. Did t	obacco use	contribute to	the cause of d	leath?
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				24a. Was		4b. Were au	topsy findings a	available
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29b. Signature and title of certifier		29c. License			29d. Date si	igned (Month	i, Day, Year)	
30 Name and address of person who completed ca	use of death (Item 23a) (Type				0120			
30 Name and address of person who completed ca	10 1967JB	RIVE. PR	EDEHC	e, M	410	2		

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Funeral Director		5. Social Security Number 219-54-1137 Usual Residence of Decedent	6. Sex 12⊠ M 2 ☐ F	7. Age (In yrs. 59	Yrs.	Months	Days	Hours	Min	8. Date of Bi (Month, D March	av. Year	950	Coun	ace (State of try) Isla	
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urs aff	β	3 ☐ Widowed 4 XX Divorced	If Yes G	ive .	974	1 □Yes	<b>≱⊠</b> No	Specify:				Specil	y:Whit	e	
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ld be f lental I ked of ic eve	To Be	Donald Seymour	Lasij					Hele		, ,	s, marae	eri Garriai	ne)		
shou and M s mar	-	19a. Informant's Name/Relations	hip (Type. Print)		19b. Mailir	ng Address	(Street			ral Route Numb	ber, City	or Town	, State, Zip	Code)	
and 2 Health		Cheryl Seymour	/ Sister	001				Cir.,		derick				04-4-	
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4+1		1/ \	RBAT 40	of death (Iter)  O West			Fre	deric	k. I	MD 2170	1				
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DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day $P^{\mathsf{M}}$ 2009 3:02 Franz J. Seiders, Jr. June 28, 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Prince George's Hospital Cheverly Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1⊠M 2□ F Yrs. 72 220-32-6102 October 0 26, 1936 Washington, DC Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 X Yes 2 ☐ No Maryland Prince George's Riverdale 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5400 54th Avenue 20737 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No IfYes, Give Year or Dates: 1955–1959 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No Specify: Specify: 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Custodial Engineer Maintenance 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Franz J. Seiders, Sr. Rose Brown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly U. Seiders / Wife 5400 54th Avenue, Riverdale, MD 20737 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 6/30/2009 4 Donation 5 Dother (Specify) Alexandria, Virginia 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 KAY Kogens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiac Arrhythmia Due to (or as a consequence of): Pulseless Electrical Activity Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Anoxic Encephalopathy Due to (or as a consequence of) Gram Positive Cocci Sepsis IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant In the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work?

Physician /Medical Examiner Examine

Physician

/Medical

Examiner

**Funeral** 

**Director** 

28a-f show

6

items 23a

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, the Wedfert Exactions or unual page.

Baltimore, Maryland 21215-0036

Directo

Funeral

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Completed

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Completed Be Certification: To

Physician/Medical

<u>\$</u>

1 Natural

2 Accident

4 Homicide

(Check only one)

3 Suicide

29a, Certifier

spital or Attending Physician: The law requires that the death certificate be executed ours after death. Hear this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, the Hospital

P.O. Box 68760.

Medical 29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

201 Milford Mill Road, Suite #105, Pikesville, MD 21208 Daniel Robert Alexander,

1 ☐ Yes 2 ☐ No

D52815

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar and manner stated

			1 _ State	epartment of Health and N Certificate of Death		jiene <sub>eg. No</sub> 2009	22665
	Physici	an	1. Decedent's Name (First, Middle, Last)	ortinidate of Death.	2. Date of Deat	th Day Year	3. Time of Death
	/Medic	cal	Harold Wexler Snider  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	06	26 2009 4c. County of Dea	10:45 A <sup>M</sup>
	Examin	ier	Montgomery General Hospital	0lney		Montgo	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	day) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,	9. Bir	thplace (State or Foreign
	Director		264-80-9431 <sup>1</sup> X M 2□F 61 Yn	s. Monard Bays Fredre Minn.	09-06-1		lorida
500	MC T		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town o	r Location			10d. Inside City Limits
Mary	i sh	tor	MD Montogomery Rock	ville			1 Yes 2 □ No
t d	or 28	Director	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Co	ountry?
ih wi	23a		4921 Bel Pre Rd.	20853		USA	·
after des	if of health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it a Medical Exemination is negligible.	y Funeral	1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 🛣 No	<ol> <li>Was Decedent of Hispanic Origin? (Split Yes, specify Cuban, Mexican, Puerton I ☐ Yes</li> <li>Yes</li> <li>No</li> <li>Specify:</li> </ol>	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
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y y	nd Mer marke	은	Jack Snider  19a. Informant's Name/Relationship (Type. Print)  19b. N	Mailing Address (Street and Number or Ru	rley Wex		Zin Cada)
, <b>MG</b>	alth an 27 is er trau			21 Bel Pre Rd. Rock			zip Code)
altilliore	Department of Health a Important: If item 27 is any Injury or other training.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of D cematery,  1 ☑ Donation 5 ☐ Other (Specify)	crematory or other place)	1	20c. Location - City or Falls Churc	
	Departn Importa any Inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Danz 1170 Rockville Pik	zansky-Go	oldberg Mer	morial Chapel
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ath ce	attending properties for use as	sician/Me	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 Ectopic pregnancy		23d. Date of de Month	livery Day Year
The law requires that the death certificate be executed	by the stached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	5 Other (specify)			July 15th
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he Hos	in 24 h he Fur pletely	ledical	(Check only one)  2 Medical Examiner: On the basis of examination and/one and manner stated.	or investigation, in my opinion, death occur	rred at the time, d	late and place, and du	e to the cause(s)
12 €	with To t	ž	29b. Signature and fitta of certifier	29c. License number		9d. Date signed (Mon	
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			30. Name and address of person who completed cause of death (Item 23a) (Ty				
	Sta	te	31. Date filed (Month, Day, Year)  JUN 29 2009  JUN 29 2009  JUN 29 2009  JUN 20 2009	Philip or Olneying			
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		For L State Registrar	State of	Maryland /		artment of F			jiene eg. No. 🥎	000	0011
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and C		Montgomery General	Hospit	:a1		Olney,	MD		Mot	ntgomeı	cy.
Funeral Director		5. Social Security Number 6. Se 054–12–5787	х ] м 2 <b>Х</b> ] F	7. Age (In yrs. last 89	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)	Year)	Coun	lace (State or Foreign try) V York
and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Loc	ation					Od. Inside City Limits
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or Attending Physician: The law requires the after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be	Completed							24a. Was ar		b. Were autop	osy findings available npletion of cause of
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sician: The certificate h rector, page	BB	25. Was case referred to medical examiner?	laneitel:			I au		th (Check only on	θ)		
Phys this al dir	은	TI les ZXIIIO		patient 2 ER/			4 LI Nursing H	ome 5 ☐ Reside			)
After funer	io	27. Manner of Death  1X Natural 5 ☐ Pending	28a. Date of (Month	, Day, Year)	o. Time of Injury	28c. Injury Work	?	28d. Describe ho	w injury occ	curred	
death death stor: / the	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e Place o	f Injury - At home,	form etro		res 2 □ No	20f Location (Ct			David March
after Direction by	Certification:	4 ☐ Homicide determined	building	g, etc. (Specify)	iaiii, sue	et, ractory, onice		28f. Location (St City or Town	reet and Nu i, State)	mper or Hura	Houte Number,
To the Hospital or Attending Physician: The law requires that the within 24 hours affer death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.		29a. Certifier (Check only 2 Medical Exami	sician: To the b	est of my knowled	lge, death and/or inv	occurred at the tin	ne, date and place	e, and due to the c	ause(s) and	manner as st	tated.
the hin 24 the F the F	Medical	one)	and manne	er stated.	IIIV						
<u> </u>	2	29b. Signature and title of certifier	MI			29c. License				ned (Month, I	
3			TU				06802	6		1261	2001
		30. Name and address of person who co					15 01	MD 2001	2.2		
Sta	to	Padmaja Bandi 1810 31. Date filed (Month, Day, Year)	32. Rec	ce Phili gistrar's Signature	ρ Dr.	Suite 3	orney.	, FIJ ZUÖ.	) 4		
Sta Registr		JUN 29 200	9 Bear	un A.	ha	Ked					

	1 - For State Registrar			artment of Hea rtificate of De		l Hygiene Reg. No	0000	22447
hysician /Medical xaminer	Decedent's Name (First, Middle, I Sharon Marie ST      Aa. Facility Name (If not institution, c)	ONER		4b. City, Town, or Loc	Moi	Ne 3	,	3. Time of Death
neral	Washington Coun  5. Social Security Number 6.	ty Hospital Sex 7. Age	(In yrs. last birthday)	Hagers	town	e of Birth nth, Day, Year)	Washin	
ector	214-76-9926  Usual Residence of Decedent  10a. State 10b. County	1□ M 2 <b>M</b> F	53 Yrs.		Jan	. 11, 1	.956 Mar	ryland  10d. Inside City Limits
or 28a-f sho ce retified a Director	Maryland Wash  10e. Street and Number	ington	Hagers	town 10f. Zip Code		10g. Cit	tizen of What Cou	1X Yes 2 □ No
al D	12 Berner Avenu	e		21740	)	υ	JSA	
ar, or tems 23a or 28a-f show Evanirar naust to rofffled at  by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 🔀 Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 XN If Yes, Give Year or Dates:	0	Was Decedent of Hispa If Yes, specify Cuban, M 1 □Yes 2 X No S	nic Origin? (Specify Yea fexican, Puerto Rican, e pecify:	s or No- etc.)	14. Race - Amer Black, White Specify: W	
vent, the Medical E	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education grade completed)  College (1-4or 5+	(Give	dent's Usual Occupation kind of work done durin DO NOT use retired)	n ng most of working	100	ind of Business/I	
even Be	17. Father's Name (First, Middle, La Grant H. Eberso	st)		18.	Mother's Name (First,	Middle, Maiden		
traumatic	19a. Informant's Name/Relationship	1 21	I	ng Address (Street and		-		
r other tra	Hope Ebersole -	daughter		N. Prospect	St., Hage		Md. 21	
= 0	1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			sition (Name of matory or other place)  Mem. Park	7/3/09			ct, Maryland
any injury once.	21. Signature of Funeral Service Lic			2. Name and Address of		<del></del>	RAL HOME	
- R O D	DOM.	11/1/1/1		15 E. Wilso			wn, Md.	
cían lical	23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	ly one cause on each line	dior	ter the mode of dying, si	uch as cardiac or respir	atory arrest,	re	Approximate Interval Between Onset and Death
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury	b. And	consequence of):	thy		Can days		
for use as the burial-transit	that initiated events resulting in death) Last	c	consequence of):	aly Az	tery /	)isea	10.	Everal Year
Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome c 1 □ Live birth 2 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specity)			23d. Date of deli Month	very Day Year
by Phy	9 ☐ Unknown  Part II. Other significant conditions		t not resulting in the u	nderlying cause given in	Part I. 23e	e. Did tobacco i	use contribute to	the cause of death?
ted	D, 26.	UB!	relli.	try fry	De II	1 kes 2	□ No 3□ Pro	obably 4 🗍 Unknown
Completed by Physic	- Light	typent	ifide	uja,		a. Was an autopsy performed? Yes 2	prior to death?	topsy findings available completion of cause of
Be Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		Other	Place of Death (Check			
ation: To	27. Manner of Death  1 Avatural 5 Pending Accident investigati	28a. Date of Injury (Month, Day,		f 28c. Injury at Work?	Nursing Home 5 28d. De	Residence scribe how injui		oify)
completely filled in by the tuneral director, page 2  Medical Certification: To Be Compl	3 ☐ Suicide 6 ☐ Could not determine	building, etc.			City	or Town, State	9)	ral Route Number,
Medical	29a. Certifier 1 X Certifying (Check only one)	Physician: To the best or aminer: On the basis of and manner stat	examination and/or in	h occurred at the time, ovestigation, in my opinion	date and place, and due on, death occurred at th	e to the cause(s e time, date and	s) and manner as d place, and due	stated. to the cause(s)
N N	29b. Signature and title of certifier	ister on	()	29c. License nu	mber 55-49	1	ate signed (Month	
5	30. Name and address of person wh	o completed cause of de	ath (Item 23a) (Type,	Print) 2 of A1	Cot Has	erst	30.	, 2174.
State	31. Date filed (Month, Day, Year)	32. Registrai	r's Signature		1.45			

DHMH 17 Rev 1/2001

			1 - State Registrar		-	Cer	tificate of	Death			Reg. No	009	224	48	
	Physicia	<b>.</b>	1. Decedent's Name (First, Mid						-	Date of De		Year	3. Time of I	Death	
	Physicia /Medic		Gilbert	Gusta	ve		Strube1		Jı	une	29,	2009	7:34	РМ	
	Examin	er	4a. Facility Name (If not institut				4b. City, Town, or		of Death			County of Death			
and the same			10815 Rosewood  5. Social Security Number		o (In ure la	et hirthday)	Hagerst If Under 1 Year	OWII If Under	24 Hrs.   g	Date of Bir		ashingto	lace (State or	Foreign	
	Funeral Director		125-07-6883	1 M 2 □ F	ge <i>(In yrs. l</i> a: <b>90</b>	Yrs.	Months Days	Hours	Min	Date of Bir (Month, Da pril 2	ay, Year) 22 <b>,</b> 19	Coun	York	roreign	
	pu >		Usual Residence of Decedent  10a, State 10b, Coun		I 100 City	Town or Loc	action					T4	0d. Inside Cit	v Limite	
-	aryla shov	ž		,								'	1 □Yes		
	the M	ect.	MD Wash	nington	Hage	erstow	n 10f. Zip Code				10a Citiz	en of What Coun			
3	be filed within 72 hours after death with the Maryland ital Hygiene.  do other than "natural", or items 23a or 28a-f show event, it a Madiral Evamina in ust be notified at	by Funeral Director	10815 Rosewoo	d Drive			21740	)				J.S.A.			
	Teath	Jera	11. Marital Status	12. Was Decedent		13. V	Vas Decedent of H		igin? (Specif	fy Yes or No		4. Race - Americ			
۰ م	or ite	T.	1 ☐ Never Married 2 ☑ Ma	Armed Forces? arried 1 X Yes 2 ☐ If Yes, Give	No	ŀ	Yes, specify Cuba	an, Mexicai Specify:		can, etc.)		Black, White, e			
2	ural",		3 ☐ Widowed 4 ☐ Divorce	ed Year or Dates:				ореспу.				Specify: Whi			
215-0036	"natu	Completed	15. Decede (Specify only high	ent's Education hest grade completed)		16a. Deced	ient's Usual Occup kind of work done o OO NOT use retired	ation during mos	st of working			d of Business/Inc actrical	dustry		
7	withir lene. than	E E	Elementary/Secondary (0-12)	) College (1-4or 5	5+)		Enginee					Electrical Manufacturing			
0	⊞ed Hyg Sther ent,	o o	17. Father's Name (First, Middle	e, Last)					er's Name (F	irst, Middle					
/land	Aenta Aenta rked tic ev	To B	Gustave Strub	el				Lau	ra (Un	known	) Str	ubel			
Mary	Z should be filled within and Mental Hygiene. is marked other than aumatic event, Its M.	_	19a. Informant's Name/Relation	nship (Type. Print)		19b. Mailin	g Address (Street	and Numb	er or Rural F	Route Numb	er, City or	Town, State, Zip	Code)		
≥ :	and and and and and and and and and and		Agnes E. Stru	bel/Wife			5 Rosewoo						·		
altimore,	ges 1 If of H If itel		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation	n 3 Removal from State	- 1		sition (Name of natory or other plac	:	Date	-	20c. Loc	ation - City or To	wn, State		
	tr Pag tmen tant: ijury	-	4 ☐ Donation 5 ☐ Other	(Specify)	Smit		g Cremato					Lthsburg			
Da	permit. Pages 1 and 2 should be Dey artment of Health and Menta Important: If item 27 is marked any Injury or other traumatic evonge.		21. Signature of Funeral Service	:e Licensee			Name and Addre						-	2	
			23a Part 1 Enter the disease	or completions that cause	d the death		01 penns				_	LOWII, MD			
			23a. Part 1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final	ist only of a ause on each li	ne.	1 1			ourdido or r	copilatory c			Approximate Interval Betw Onset and D	veen leath	
	hysician /Medical		disease or condition resulting in death)	a. Due to (or as	(0/ (1/	ence of):	nfore f	1201					( DCy		
r E	Examiner			Due to (or as	a conseque	ince oi).									
7	. +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ence of):									
	ecute ind transi	Examiner	that initiated events	С											
Š,	oe ex clan a surial-		resulting in death) Last	Due to (or as	a conseque	ence of):									
00/00	physi the b	Medical		d											
X	certili oding se as	~	IF FEMALE:	23c. If yes, outcome	of pregnan	cy					2	3d. Date of delive	nn.		
0	atter for u	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a	2 ☐ Fetal c	death 3∟	l Ectopic pregnanc l Other <i>(specify)</i> _	у				Month	-	'ear	
) )	by the	Physician	9 Unknown	9 ☐ Unknown											
S, T	gned gred	by P	Part II. Other significant condi	itions contributing to death b	out not result	ing in the ur	derlying cause giv	en in Part I	ı.	23e. Did	tobacco us	se contribute to the	ne cause of de	eath?	
Records,	equire en siç ould b	pe	TYPICU	repetes 11/1	TUS					17/24	¥es 2□	]No 3☐ Prob	ably 4□U	nknown	
3	as be	Completed	Hypottension	hyperl	ipide.	m16				24a. Was		24b. Were auto	psy findings a	vailable	
r	zate h	Com	Chance Ob	ostructure O.	i/mo	ner	disers	S.R		perfo 1 □ Yes	ormed? 2-54No	death? 1 □ Yes			
N Ear	cram sertifi ector,	Be	25. Was case referred to medic examiner?			7	104		e of Death (C	Check only	one)				
5	this aldir	<u></u>	1 Yes 2 1/No 27. Manner of Death	Hospital: 1 ☐ Inpatii 28a. Date of Inju	ent 2 E	R/Outpatien 28b. Time of		4 🗆 🕦				Other (Specif	y)		
VISION OF	After funer	tion	Natural 5 ☐ Pend		iy, Year)	Injury	Worl	yaı k?  Yes 2□		d. Describe	now injury	occurred			
	deat ctor: by the	fica	3 ☐ Suicide 6 ☐ Coul	ld not be 28e. Place of Inj	ury - At hom	ne, farm, stre	eet, factory, office			. Location (	Street and	Number or Rura	l Route Numb	ber,	
$\frac{2}{5}$	a after a Dire	Certification:	4 ☐ Homicide deter	building, et	tc. (Specify)					City or To	wn, State)				
4	To the hospital of Attending Priystoan: The law requires that the beant certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.		29a. Certifier 1 Certify (Check only 2 Medic	ying Physician: To the best al Examiner: On the basis of	of my know	ledge, death	occurred at the til	me, date a	nd place, and	d due to the	cause(s)	and manner as s	tated.		
1	the F	Medical	one)	and manner st	ated.	511 and 51 m			alli occurred	at the time					
F	Zon with	2	29b. Signature and title of certif	ler	Λ	$\cap \cap$	29c. Licens		6413	>		signed (Month, $V/3 \omega/2$	-		
					(	0		003	0 70			130/1	007		
SH	1-4+1		30. Name and address of persons Sanjay Saxena				erint) agerstown	n. MT	2174	10					
ا احب	Sta	te	31. Date filed (Month, Day, Yea	ar) 32. Registr				, 1111	<u> </u>						
	Registr		JUL 0	1 2009 Series	ua,	1. A	arke								

			Please T					Ensure All			ble.		
			For State Registrar	State of Ma	aryland /		artment of F <i>rtificate of I</i>	lealth and M Death		iene <sub>eg. No</sub> 2	00	221	449
			Decedent's Name (First, Middle, Last)				•		2. Date of Deat	h	<u> </u>	3. Time o	f Death
	Physicia		Raymond Nol		7.				Month	Day よろ。	Year	132	5 PM
man night	/Medic Examin		4a. Facility Name (If not Institution, give				4b. City, Town, or	Location of Death	0	4c. County			
	Examin	eı	Memorial Hospi		- Co saton	<b>1</b>	Easte	20		Tale	100		
	Funeral Director		<ol> <li>Social Security Number</li> <li>Sex</li> </ol>	7. Ag	e (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day, 11/23/1	Year)	9. Birthp	place (State ntry) ginia	or Foreign
	D		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	ocation					I0d. Inside C	City Limits
	Maryla f sho	to	Maryland Talbot			Eas	ton					1 □ Yes	2 7 No
	the 1	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of	What Cour	ntry?	
	3a or		7383 Dale Avenu	2			21601			USA			
	ms 2	Funeral	11. Marital Status	12. Was Decedent		13.	Was Decedent of H	ispanic Orlgin? (Spe an, Mexican, Puerto F	cify Yes or No-			can Indian,	
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, It. Mo. Cot. Ex. nit or must be notified at once.	ρ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 ☐ I If Yes, Give Year or Dates:	No		1 ☐ Yes 2 💢 No	Specify:	ncan, etc.)	Specif	ick, White, fy: Wh	nite	
21215-0036	in 72 ho n "natur No Seco	Completed	15. Decedent's Edu (Specify only highest grad	e completed)		(Give	edent's Usual Occup e kind of work done o DO NOT use retired	durina most of workir		16b. Kind of B	usiness/In	dustry	
212	with giene r than	l l	Elementary/Secondary (0-12)	College (1-4or 5 2 years	o+)	Me	chanic	_		E1evat	ors		
힏	othe othe	a '	17. Father's Name (First, Middle, Last)					18. Mother's Name					
<u>a</u>	and be denta rked ric ev	To B	Walter Noland	Stu1tz				Mag	gie Jew	el Holo	:omb		
Maryland	shou s ma		19a. Informant's Name/Relationship (Ty				-	and Number or Rura				o Code)	
Σ	is 1 and 2 soft Health a tem 27 is other trau		Martha Frances St	ultz/ Wif				nue, East					
altimore,	Pages 1 ient of H nt: If iter ry or oth		20a. Method of Disposition  1  Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)	temoval from State	ceme	etery, cre	osition (Name of matory or other plac ans Cemet	e)		20c. Location Che1te	•		
Balti	Departir Mporta any Inju		21. Signature Funda Sovice Licens	ee	, 112	2	2. Name and Addre	ss of Facility Geor ons Island	ge P. K	Kalas F	unera	1 Hom	e
			23a. Part1. Enter the disease, or compl	ications that caused	the death [						I, MI	Approxima	
. =			shock, or heart fallure. List only of Immediate Cause (Final	ne cause on each li	ne.	o not en	iter the mode of dyn	ig, such as cardiac o	respiratory arr	oot,		Interval Be Onset and	etween
	Physician /Medical		disease or condition resulting in death)	a	a constrouence		NCIN	cma			-		
	Examiner			Due to (or as		را ما د	C14 . C						
		ЭĒ	Sequentially list conditions, if any leading to immediate	Due to (or as	a consequen								
	executed n and al-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	o									
o,		HAM	resulting in death) Last	Due to (or as	a consequen	ce of):							
68760	ate b hysici he bu	<u>ica</u>		d									_
39	ertific ling p e as t	Mec	IF FEMALE:						-				
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal de	ath 3	☐ Ectopic pregnand ☐ Other (specify)	y			ate of deliv	very Day	Year
σ.	that the ed by detac		Part II. Other significant conditions co	ntributing to death b	out not resultin	g in the ı	underlying cause giv	en in Part I.	23e. Did to	bacco use cor	ntribute to	the cause of	death?
Records,	quires t	ed by							1)24	és 2□No	3□ Pro	bably 4	J Unknown
000	law requir as been s 2 should	Slete							24a. Was a		. Were aut	opsy finding	s available
E E	ding Physician; The lav h. After this certificate has funeral director, page 2	Completed							autops perfor 1 □ Yes		death? 1 ☐ Yes	ompletion of	cause of
of Vital	Physician; r this certifica ral director, p	Be	25. Was case referred to medical examiner?	Hospital:			Oth	26. Place of Death		-			
of	Phys this	은	1 ☐ Yes 2 ☐ No	28a. Date of Inju		Outpatie	ent 3 🗆 DOA	4 LI Nursing Ho	me 5 Resid			ify)	
O	dlng h. After funer	tion	1 Natural 5 ☐ Pending	(Month, Da		Injury	Wor	k?  Yes 2 □ No	Edd. Desdribe III	ow mjury occu	1100		
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director. Afte completely filled in by the fune	Certification: To	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, el	ury - At home c. (Specify)	, farm, si	treet, factory, office		28f. Location (S City or Tow	treet and Num n, State)	ber or Rui	ral Route Nu	mber,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in							me, date and place,					
	n 24 h	Medical	(Check only 2 Medical Exam one)	ner: On the basis of and manner st		and/or i	nvestigation, in my	opinion, death occurr	ed at the time, o	late and place	, and due	to the cause	(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier				29c. Licens	se number	2	29d. Date sign	ed (Month	, Day, Year)	
	~ ~ ~	0		0-6	70	20 v	10 000	553110	3	June	23	200	29_
	1,600		30. Name and address of person who c					oot Fastor	Marul	and 216	501		

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

JUN 25 2009

Dennis Michael DeShields, 219 S. Washington Street, Easton, Maryland 21601
31. Date filed (Month, Day, Year) 32/Registrar's Signature

09-04898 William Sippel Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Amani Oippoi	1- For State Certifica	te of Death	Reg. No. 2009	9 22451
Physician/	Registrar  1. Decedent's Name (First, Middle,Last)		ate of Death onth Day Year	3. Time of Death
Medical Examiner	William Albert Jenkins Sippel	Ju	ne 21, 2009 4c. County of Deatl	0038 hrs
	Facility Name (if not institution, give street and number)     Anne Arundel Medical Center	4b. City, Town, or Location of Death Annapolis	Anne Arundel	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birth	"	Date of Birth (MM/DD/YYYY) 9. Bir	an .
Director	215-52-6491   1 M 2 F 61	Yrs.	04/06/1948	ountry) MD
any	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town of			10d. Inside City Limits
Varyland 28a-f show 1 at once. ector		ood Forest		1 Yes 2 X No
the Maryland a or 28a-f sh tified at one Director	10e. Street and Number	10f. Zip Code 21405	10g. Citizen of What Cou	intry?
	511 Little John Hill  11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? ( Specify	Yes or No- 14. Race - Amer	ican Indian, Black,
r death with or items 23 must be no Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto Ricar		
urs afte ural", miner	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) 16a. D	Yes 2 X No specify: ecedent's Usual Occupation (Give kind of work d		ite /Industry
5-0036 ed within 72 hour other than "natu the Medical Exar Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	uring most of working life. DO NOT use retired)		
5-0036 led within 72 Hygiene. other than the Medical	17. Father's Name (First, Middle, Last)	omputer Analyst	DOD t, Middle, Maiden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica FO BE COMPIE	John Parker Sippel	Ruth Jen		
D 21.		Mailing Address (Street and Number or Rural I		
Baltimore, MD 21215-00 permit. Pages I and 2 should be filted with Department of Health and Mental Hygien Important: If item 27 is marked other injury or other traumatic event, the Me To Be Corr		1 Little John Hill, Sh Disposition (Name of cemetery, Date		
10re	1 Burial 2 X Cremation 3 Removal from State cremato	ry or other place) ore Crematory 6/26/	2009 Baltimore	MT)
altin mit. Pa partmet portan ury or	21. Signature of Funeral Service Licensee	22. Name and Address of Facility John		
	Myelin T. Klobert	147 Duke of Gloucest		
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line.		iratory arrest, snock, or neart	Approximate Interval Between Onset and Death
xaminer	Immediate Cause (Final disease or condition resulting in death)  Atherosclerotic Cardiovascul.	ar Disease		
5	Sequentially list conditions,   b.     b.			
ted Insit Examiner	Obesse or injury that initiated C.			
nd ransit	events resulting in death) Last  Due to (or as a consequence of):  d.			
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.  the Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial - transit silical Certification: To Be Completed by Physician/Medical Exi	UNPENDED AMENDED	· · · · · · · · · · · · · · · · · · ·	C-97- 848	
8760, ifficate be ng physic is the buri	IF FEMALE: 23b. Was decedent pregnant in the post 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregnancy	23d. Date of deliver Month	ry Day Year
b. Box 687 the death certific by the attending loched for use as the	past 12 months?  4 Pregnant at time of death 5	Other (Specify)		
D. Be trucked the by the ached for	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?
ires that to signed by the detac			1 Yes 2 No 3 Pro	bably 4 🗹 Unknown
of Vital Records, is Physician: The law requires offer this certificate has been signeral director, page 2 should be not To Be Completed			autopsy prior to	utopsy findings available completion of cause of
Recol The law icate has page 2 sl		1	performed? death?  Yes 2 No 1 Y	es 2 No
ital Recidian; The lactificate lifector, page	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ✓ ER/Out	26.Place of Death (Check only of tpatient 3 DOA Other Nursing Hor		
of Vitaling Physic I.  After this funeral dir	1 V res 2 No		Describe how injury occurred	-
ion ttendir feath. ttor: A the fu	Natural 5 Pending 2 Accident Investigation	1 Yes 2 No		
Division of spiral or Attending hours after death.  Inneral Director: Aft y filled in by the fund.  Certification:	Suicide 6 Could not be determined (Speciful		Location (Street and Number or Roor Town, State)	ural Route Number, City
D To the Hospital within 24 hours To the Funeral completely filled	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, and due t	to the cause(s) and manner as sta	ited.
To the Hos within 24 h To the Fun completely	one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.			
Š	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Mo	onth, Day,Year)
Sup	30. Name and address of person who completed cause of death (Item 23a)	0.0	035 2 1, 2000	
1/100		Penn Street, Baltimore, MD 21201		
State	31. Date filed (Month, Ray, Year) 2009 32. Registrar's Signature	1.41		

		Please	e Type or Prin	it in Black Ind					egible.	
		For State Registrar	State of Ma		rtificate of			Reg. No. 🤈	000	221.51
Physicia		Decedent's Name (First, Middle, L     MILDRED LOUISE T					2. Date of Dea Month <b>JUNE</b>		2009	3. Time of Death 5:30 P M
/Medic Examin		4a. Facility Name (If not institution, g		DERCARE	4b. City, Town, o	or Location of Death		4c. Co	ounty of Death	
Funeral Director				e (In yrs. last birthday) 32 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day MAY 5,	, Year)	9. Birthp Cour MARY	lace (State or Foreign try) <b>LAND</b>
and	ĺ	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				1	0d. Inside City Limits
Maryl	ţo	MARYLAND CHARL	ES	NEWBURG						1 □Yes 2 😿 No
n with the	Funeral Director	10e. Street and Number 14415 ROCKPOINT	ROAD		10f. Zip Code 20664				n of What Cour D STATE	-
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantmer must be notified at once.	by Funer	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 ☑ N If Yes, Give Year or Dates;	lo l	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	Hispanic Origin? (Sp. an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		. Race - Americ Black, White,	etc.
iin 72 hou n "natura	Completed	15. Decedent's l (Specify only highest g	Education grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of works	ing	16b. Kind	of Business/Inc	dustry
ed with ygiene er tha t, the	Som	6TH GRADE	College (1-4or 5-	HOU	JSEWIFE				MEMAKER	
uld be file Mental H arked oth	To Be	17. Father's Name (First, Middle, Last JOSEPH THOMAS	st)			18. Mother's Name	e (First, Middle,  MOORE TI			
and 2 sho saith and 1 27 is me er traume		19a. Informant's Name/Relationship ALEASE SLYE / DA	(Type. Print) UGHTER			NT ROAD,		-		Code) 20664
Pages 1 and the first of the int. If item		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		20b. Place of Dispo cemetery, cren BRINSFIFID-	matory`or other pla	ce)	Date 4, 2009 (		ition - City or To	wn, State  MARYLAND
permit. Departm Importa any inju		21 Structure of Funeral Service Lo	how fine	22	2. Name and Addre	ess of Facility	-			
Physician /Medical Examiner		23a. Part 1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	mplications that caused ly one cause on each lin	the death. Do nonthe.		ing, such as cardiac			AD, MAK	Approximate Interval Between Onset and Death
	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Drew	e consequence of): a consequence of):	. Acz	17 FDWK	n Typ	>,=		years.
Attending Physician: The law requires that the death certificate be or death. ector: After this certificate has been signed by the attending physicia by the funeral director, page 2 should be detached for use as the bur	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1  ☐ Live birth 4  ☐ Pregnant at 9  ☐ Unknown	2 Fetal death 3	☐ Ectopic pregnand ☐ Other (specify) _	су		23	d. Date of deliv Month	ery Day Year
e law requires that the de has been signed by the e 2 should be detached	হ	Part II. Other significant conditions	contributing to death bu	ut not resulting in the u	nderlying cause giv	ven in Part I.		obacco use		ne cause of death?
The law req ate has beer page 2 shou	Completed						24a. Was a autop perfor	sy	prior to co death?	ppsy findings available mpletion of cause of
ician; sertific ector,	Be	25. Was case referred to medical examiner?	Hoopitali		low	26. Place of Deat				
Phys or this oral dir	5. To	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	ent 2 ER/Outpatier ry 28b. Time o	of 28c. Inju	iry at	ome 5 ☐ Resid			(y)
To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ht completely filled in by the funeral director, page	Certification:	1 Natural 5 Pending 2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	be 390 Place of Init	urv - At home, farm, str		rk? ]Yes 2 □No	28f. Location (S		Number or Rure	al Route Number,
Hospitai o 24 hours af Funeral D tely filled ir	edical Cer		Physician: To the best of aminer: On the basis of	of my knowledge, deat f examination and/or in						
To the within 2 To the comple	Med	29b. Signature and title of certifier	and manner sta	D~ m	29c. Licen	senumber		29d. Date	signed (Month,	Day, Year)

State Registrar

30. Name and address of person who completed in the second

			State of Maryland / Dep	artment of Health and N	/ 11 11 5	22452
			Registrar  1. Decedent's Name (First, Middle, Last)	Timeate of Death	Reg. No	3. Time of Death
	Physicia		William Larry Smith, Sr.		June 24, 2009	12:58 P.M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of De	
	LAGIIIII	CI	Anne Arundel Medical Center	Annapolis	Anne Ar	undel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	(Month Day Year)	irthplace (State or Foreign Country)
	Director		217-30-1125   ¹☒M 2□F   72 Yrs.		12/18/1936 Nor	th Carolina
	and t		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Low	ocation		10d. Inside City Limits
	Mary -f sho ied a	to	Maryland Talbot Cordova			1 □ Yes 2🏋 No
	r 28a	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What (	Country?
	filed within 72 hours after death with the Maryland Hygiene. Hygiene. than "natural", or items 23a or 28a-f show ant, the Amalical Examiner must be notified at	al D	12390 Blades Road	21625	U. S. A.	
	ems sr.mu	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.) 14. Race - Ar Black, Wh	nerican Indian, ite. etc.
020	or it	by Fu	1 ☐ Never Married 2 🕱 Married 1 ☐ Yes 2 📉 No	1 ☐Yes 2X No Specify:		White
Ś	hours tural"		3 ☐ Widowed 4 ☐ Divorced Year or Dates:	edent's Usual Occupation	16b, Kind of Busines	s/Industry
2	in 72 n"nai Mulici	olete	(Specify only highest grade completed) (Give	e kind of work done during most of work DO NOT use retired)		1.
7	r thar	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Poli	ceman	County	
ם מ	e filec al Hyg othe vent,	Bec	17. Father's Name (First, Middle, Last)		e (First, Middle, Maiden Surname)	
<u> </u>	Ments Ments arked atic e	2	Claude William Smith		llizabeth Best	
<u>0</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mudical Evaminer must be notified at once.		1 1 2 2	ing Address (Street and Number or Rui		, Zip Code) .625
ב ע	1 and Health Fm 27 ther t			Blades Road, Cord	Date 20c. Location - City	
2	nt of l		1 M Burial 2 Cremation 3 L Removal from State	matory or other place)	7/2009 Brentwood,	
	nit. Pa artme ortani injury		Tabellation of action (opening)	22. Name and Address of Facility Rot	·	•
0	Deparation of the control of the con			6000 Annapolis Roa		
			23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
, F	hysician		Immediate Cause (Final disease or condition	~		Onset and Death
	/Medical		resulting in death)  a.  Due to (or as a consequence of):			•
	Examiner	L.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
	red Isit	nine	if any, leading to immediate Due to (or as a consequence of): Cause (Disease or injury			
	execu n and al-trai	Examiner	that initiated events resulting in death) Last c			
0000	fricate be executed physician and the burial-transit	dical E	d			
8	riffical ng phy as th	ledi			-	
Š	th cel	an/N	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3	☐ Ectopic pregnancy	23d. Date of o	delivery Day Year
5	e dea the at	Physician/Me	in the past 12 months?  1	Other (specify)		Day You
	hat th ed by detacl		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death?
֓֞֝֝֟֝֟֝֟֝ <del>֚</del>	isigne d be	d by	<u></u>	, , ,	1 ☐ Yes 2 ☐ No 3 ☐	Probably 4 Unknown
cords	w requ	Completed			24a, Was an 24b, Were	autopsy findings available
ב ב	he lay e has age 2	шć			autopsy prior to death	o completion of cause of ?
<u> </u>	an: I tiffical tor, pa	a)	25. Was case referred to medical	26. Place of Dea	1 ☐ Yes 2 ☐ No	es 2□No
<b>&gt;</b> :	iysict iis cer direc	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	Othor	ome 5 ☐ Residence 6 ☐ Other (S	pecify)
NISION O	ng Ph fter th neral	Ľ:uc	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury (Month, Day, Year) Injury	of 28c. Injury at Work?	28d. Describe how injury occurred	
2	tending earth.	catio	2 Accident investigation	M 1 □Yes 2 □No		
<u> </u>	or At after d Direct in by	Certification:	3 ☐ Suicide 4 ☐ Homicide  3 ☐ Suicide 4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  5 ☐ Could not be determined  4 ☐ Homicide  4 ☐ Homicide  5 ☐ Could not be determined  4 ☐ Homicide  5 ☐ Could not be determined  5 ☐ Could not be determined	treet, factory, office	28f. Location (Street and Number or City or Town, State)	Hural Houte Number,
-	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  within 24 hours after death.  To the Furteral Director: After this certificate has been signed by the attending p. completely filled in by the funeral director, page 2 should be detached for use as:		29a. Certifier Certifying Physician: To the best of my knowledge, dea			
:	ne Ho n 24 h ne Fur	edical	(Check only Medical Examiner: On the basis of examination and/or and manner stated.	Investigation, in my opinion, death occu	rred at the time, date and place, and o	lue to the cause(s)
i	Vithi Comp	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mo	
	Gin		M MD	017915	June 26, 2	.009
'	My.		30. Name an address of person who completed cause of death (Item 23a) (Type	Print)	of Amphis M	21411
	Sta	ite	31. Date filed (Month, Day, Year)  32. Aegistrar's Signature	اد احا ما ما اد ما	1416 hay 14	V C1-1V 1
	Regist		31. Date filed (Month, Day, Year)  JUN 26 2009  32. Registrar's Signature	all		

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			1 _ State	State of Ma	aryland		rtment of H		l Mental Hy		0.00		0.0	1 = 0
	Physici	an	Registrar  1. Decedent's Name (First, Middle, Last)				imoate of E		2. Date of De	Day	Z U L	ear	. Time of	
	/Media	cal	Marie Tyner				4b. City, Town, or	Landin of Da	June 2		09 County of I	1	100	A M
4	Examir	er	4a. Facility Name (If not institution, give st Sunrise Assisted	,			Rockv		atn			omery		
	Funeral		5. Social Security Number 6. Sex	_		ast birthday)	If Under 1 Year Months Days	If Under 24 H Hours Mi			9.	Birthplace Country)	e (State c	or Foreign
	Director		Usual Residence of Decedent	M 2X F	9	8 Yrs.			July 0		10	Fra		
	/land ow		10a. State 10b. County		10c. City	, Town or Lo	cation					10d.	Inside Ci	ity Limits
	a-f sh	ctor	MD Montgome	ry	Ro	ckvi1	Le						1 X Yes	2 □ No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	en of Wha	t Country?	)	
	s 23a		8 Baltimore Road	2. Was Decedent 8	Ever in 11.5	12.1	20850	popio Odejp?	(Specify Vac or N		rance	e American ī	Indian	
	riter de	Funeral	11. Marital Status  1 Never Married 2 Married	Armed Forces? 1 ☐ Yes ② N		1	Vas Decedent of His f Yes, specify Cubar		erto Rican, etc.)	)-   '		White, etc.		
93	ours a	by	3 ☐ Widowed 4 🖾 Divorced	If Yes, Give Year or Dates:			□Yes 2XNo	Specify:			Specify:	Cauc	asia	n
<u>ب</u>	"natu "natu	Completed	15. Decedent's Educa (Specify only highest grade	ation completed)		16a. Deced	lent's Usual Occupa kind of work done d OO NOT use retired)	tion uring most of w	vorking	16b. Kin	d of Busin	ess/Indust	ry	
7	withiir iene. than the Me	ошо	Elementary/Secondary (0-12)	College (1-4or 5	+)		ousewife	'		0	wn Ho	ome		
פ	e filed al Hyg other vent, i	BeC	17. Father's Name (First, Middle, Last)					18. Mother's N	lame (First, Middle	e, Maiden S	Surname)			
y Na	ould b Menta arked artic e	10 E	Joseph Champcommun			,		Elspe	th Hodge	son				
Mar	as 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  of Health and Mental Hygiene.  The All marked other than "natural" or items 23a or 28a-f show from 27 is marked other than "natural" or items 23a or 28a-f show from 27 is marked other than "natural" or items 23a or 28a-f show from 1 the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type John Tyner/Son	e. Print)		1	g Address <i>(Street a</i> Halpine l			-	Town, Sta		de)	
<u>ရ</u>	tem 2		20a. Method of Disposition		20b. Pl	ace of Dispo	sition (Name of		Date			y or Town,	State	
ē			1 ☐ Burial 2 XCremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State			natory or other place oln Crema		/01/2009	Bre	ntwo	od, M	D	
	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licenses	MO14	462		. Name and Addres							
n	6 # 5 P						040 Rockv				, MD	208		
		6 A	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Couse (Final				er the mode of dying	g, such as card	iac or respiratory a	arrest,		Int On	proximat erval Bet set and I	ween Death
	Physician /Medical		disease or condition resulting in death)	End S							_	2 1	Mont!	hs
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	sit sed	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury	Due to (or as a	a consequ	ence of):								
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8/60,	cate be executed physician and the burial-transit	dical	d.											
Š	ertifica ling ph e as th	Med	IF FEMALE:											
X P P	death certific e attending p d for use as	Physician/Me	in the past 12 months?	<ul> <li>c. If yes, outcome     <ul> <li>1□Live birth</li> </ul> </li> <li>4□Pregnant at</li> </ul>	2 🗆 Fetal	death 3	Ectopic pregnancy Other (specify)			2	3d. Date o Month		у ,	Year
j.	the d	nysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown	time or de	, au OL	Totale: (Specify)	_						
ρ, J	The law requires that the ditte has been signed by the vage 2 should be detached	by PI	Part II. Other significant conditions cont	-	ıt not resu	Iting in the ur	derlying cause give	n in Part I.				ite to the c		
0.0	requir een si nou!d l		Advanced Demetia						_ 1□	Yes 2X	]No 3[	Probably	/ 4 🗆 L	Jnknown
Vital Records,	e law has b	Completed							24a. Was		prio	re autopsy r to comple	findings a	available ause of
	10 52		25. Was case referred to medical						1□ Yes	2 <b>X</b> No	dea 1 □	Yes 2	No	
>	Attending Physician: r death. ector: After this certific by the funeral director,	o Be	examiner?	ospital: 1 ☐ Inpatie	nt 2 ☐ E	R/Outpatien	t 3 DOA Othe		eath <i>(Check only</i> Home 5□Res		□Other (	(Specify)		
ם כו	ding Phys h. After this funeral di	T :uc	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y Year)	28b. Time of Injury	28c. Injury Work	at ?	28d. Describe					
DIVISION	ftendi leath. tor: A the fu	catio	2 Accident investigation 3 Suicide 6 Could not be	One Place of lain	44 h			′es 2□No	001.1					
	ipital or Attenors after death ours after deatheral Director: filled in by the	Certification:	4 Homicide determined	28e. Place of inju building, etc	iry - At nor c. (Specify	me, farm, stre	еет, тастогу, оппсе		28f. Location ( City or To	(Street and wn, State)	Number	or Rural Ro	oute Num	nber,
	To the Hospital or A within 24 hours after or To the Funeral Direct completely filled in by	SalC	29a. Certifier 1 X Certifying Physl (Check only 2 ☐ Medical Examin	cian: To the best of	of my knov	vledge, death	occurred at the tim	e, date and pla	ace, and due to the	cause(s)	and mann	er as state	d.	
	To the Hos within 24 ho To the Fun completely	fedical	оле)	and manner sta		ion and/or in			ccurred at the time					s) 
	Vwit To Cor	Σ	29b. Signature and title of certifier	R. Mi	Tto (	) now	29c. License D00613		:		-	Nonth, Day 2009	, rear)	
,	J		30. Name and address of person who con				ン  Print)							
			Sharma R. Mittal, M					Suite	152, Roc	kvill	e, M	20	850	
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signat	ure for	Ked .							

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Gale P. Turner June 2009 2:19 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 M 2 F Yrs 216-48-8140 8-14-1948 Maryland Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits Yes 2 No <u>Maryland Anne Arundel</u> Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1780 B Belle Drive 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 27 Married 1 ☐ Yes 21 No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Janitor US Naval Academy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Blake Lucille Thomas 19a. Informant's Name/Relationship (Type. Print) (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1780 B Belle Drive Annapolis, Md. 21401 Gerald E. Turner, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/29/09 4 Donation 5 Other (Specify) Metro Cr3matory Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Reese & Sons Mortuary, P.A. West St. Annapolis, Md. 21401 1 B. Ranom00883 821 23a. art1. Enter he disease, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CUT 6 ESPIRATORY disease or condition resulting in death) HIOR Due to (or as a consequence of): CXACCR TATIO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence on, Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 666 24a. Was an 25. Was case referred to medical examiner? 1 ☐ Yes 2 🗷 No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Physician /Medical Examiner Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

ģ

Completed

Be

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentral Hygiene. Important: If them 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, ir it is referred from the multiple at any injury or other traumatic event, ir is referred.

Maryland 21215-0036

Baltimore,

Pages 1 nent of H

sician and burial-trans attending pl for use the detached cate has been signed by page 2 should be detact certificate director, this funeral After To the Hospital or Attence within 24 hours after death To the Funeral Director:

Physician/Medical

Completed by

Be

Certification: To

Medical

law requires that the death certificate be executed

P.O. Box 68760

Division of Vital Records,

Physician; The

or Attending

1 Yes 2 No 27. Manner of Death 1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

5 ☐ Pending investigation

6 Could not be determined

28a. Date of injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

PR. ANNAPOLIS, MP

28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier

147494

29d. Date signed (Month, Day, Year) 6/22/09

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LANGSTON 0 1616 FOREST 31. Date filed (Month 25

State Registrar

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Mallory Paige That amend ite:			Si a per	tate of fh.e	Maryland b.6/30	I / Departi	ment of icate of	r Health a FDeath	na went	ai Hygie			20	09 2245	
Physici		Registrar 1. Decedent's Nam	_				-	Dodin			ate of Death			3. Time of Death	
Medical Exami	217.77		ry Pa		Thomas					Ju	onth ne 24, 20	Day 009	Year	2035 hrs	
		4a. Facility Name (		on, give str	eet and numbe	r)	1	b. City, Town,		of Death		1	County of Dea		
		904 Lemmo		r				Baltimore			D. L C Dieth		altimo	re sirthplace (State or Foreign	
Funeral Director		5. Social Security N 215-33-0		6. Sex		ige (In yrs. last 17	birtnday) Yrs		ays Hours	1	7-12-		1 Ma	country) aryland	
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ow any	- 1		10b. County					IOH						1 X Yes 2 No	
ryland a-f sh	녆	MD 10e. Street and Nu	Balti mber	more		Balt	imore	10f. Zip Code			10	g. Citize	en of What Co	ountry?	
th the Maryland 23a or 28a-f show notified at once	Director	904 Lem		reet				2122	3			1	USA		
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72 hou	eted	Elementary/Sec			College (1-4 c	,		ost of working							
036 vithin ene. er thar	Comple	12			none		Sal	espers		Retail					
21215-0036 Mid be filed within 7 Mental Hygiene. marked other than	ပ္တို	17. Father's Name			Īν			18.Mother's Name (First, Middle, Maiden Surname)  Lisa Burton							
212' ald be Mental marke	o Be	Daniel Ray Thomas, Jr. Lias Informant's Name Relationship (Type Print) thomas / Lisa Burton/mother mother 904 Lemmon St.,										ber, Cit	y or Town, Sta	ate, Zip Code)	
ore, MD 21215-0036 is I and 2 should be filed within 72 hours after the Habil and Mental Hygiers If item 27 is marked other than "natural", ner traumatic event, the Medical Examiner	-	L <del>isa B</del> ı	rton/i	mothe	n rnoma	other	904 I	emmon	St., B	altimo	re, M	D 2	1223		
re, f I and f Healt f item		20a. Method of Dis		n 3	Removal from S	l l	ce of Dispos matory or ot	sition (Name of her place)	cemetery,	Dat	te	20c. L	ocation - City	or Town, State	
imore Pages I ; nent of H ant: If it or other I		Donation 5			Celloval from C		chwood	Cemet	ery	6/27/	2009	Pr	incess	Anne, MD	
Baltimore, bermit. Pages I an Department of Hea Important: If iter		21 Signature of Fi	inera Cardic	Licensee	$\sqrt{0}$	100005	$\mathbf{H}^{22}$	name and Addr nman Fu	ess of Facility neral	Home					
	$\supset$	23a. Part I. Enter t	ne disease o	r complicat		100295	111	573 Som	erset				Anne.	MD 21853 Approximate Interval	
Physician /Medical		failure. List or	nly one cause	e on each I		33 (115 4344111 2	o not onto		,		,			Between Onset and Death	
xaminer	0	Immediate Cause or condition result				nsequence of):									
		Sequentially list co		b											
	nin	if any, leading to it cause. Enter Und	erlying Cause		to (or as a cor	isequence or):									
ed nsit	Examiner	(Disease of injury events resulting in		Due	to (or as a cor	nsequence of):									
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760, icate be physic the bur	Med	IF FEMALE:	SC		3c. If yes, outo	come of pregna	ncy					23d	. Date of deliv	-	
Box 68760, re death certificate be rithe attending physic rithe attending physic ned for use as the bur	sician/M	23b. Was deceden past 12 month		the .	Live birth	at time of death	,	etal death	3 Ectopi	c pregnancy			Month	Day Year	
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s, P.O. B ires that the d is signed by the	y Phys	Part II. Other sign	ificant cond	itions co	ntributing to de	ath but not resu	ulting in the	underlying cau	se given in Pa	art I.		_		to the cause of death?	
S, P.  Lires th  signe d be de	ed by									— l				robably 4 Unknown	
cords, law requin	Completed						_				24a. Was a autop			autopsy findings available to completion of cause of	
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tal Recinian: The lacentificate lector, page	Be (	25. Was case refe examiner?	rred to medic	al [Hosp	nital:				lace of Death	(Check only					
f Vid Physic er this	ို	1 ✓ Yes 27. Manner of Dea	2 No	lilost	28a. Date of I		R/Outpatien 8b. Time of		Injury at Work	Nursing Ho			nce 6 🗸 Ot	her: Scene	
Division of Vital Records, the or Attending Physician: The law requirant after death.  The Director: After this certificate has been seled in by the funeral director, page 2 should 1	Certification:	1 Natural		nding	Jun 24, 200		0000 hrs	· ·   -	Yes 2	- Isut	oject han				
risic r Atter er dea irector	ficat	2 Accident 3 Suicide		estigation and be	28e. Place of	f Injury - At hom	e, farm, stre	et, factory, offi	ce building, e	tc. 28f.			nd Number or	Rural Route Number, City	
Divisior Hospital or Attenc 24 hours after death Funeral Director: tely filled in by the	erti	3 Suicide 4 Homicide		ermined	(Specify) T	ownhouse	Rowhou	se		904	or Town, S Lemmon	state) Street,	Baltimore, I	MD	
Division of Vital Records, P.O. Box 68760, with Edental or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		29a. Certifier (Check only one)		Physician:	To the best of	my knowledge xamination and	, death occu	irred at the time	e, date and planion, death of	ace, and due	to the caus	e(s) an	d manner as s	stated. the cause(s)	
To the within 2 To the complet	Medical	29b. Signature and	J	an	d manner state				cense number					Month, Day, Year)	
	_	0	M.	), _					.C.M.E.				e 25, 2009		
		30. Name and add	Iress of perso	on who com	pleted cause of	of death (Item 2)	3a)			<del>-</del>		1			
		Donna M. \				dical Exami		1 Penn Stre	eet, Baltim	ore, MD 2	21201				

DHMH 17 Rev 1/2001 OCME 2006

State

Registrar

OCME

31. Date filed (MOTUN 3 0 2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** Dixie Marguerite Wilson <u>12:</u>10 A<sup>M</sup> June 30, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Country House Residences Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🕅 F 223-44-1937 100 Oct 24 Director 1908 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, tra Medical Examination must be notified at Y∏Yes 2 ☐ No Director MD Kitzmiller Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 215 E. Main Street 21538 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 □Yes 2X No Specify: þ Specify: 3 X Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene, is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Teacher Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Daniel Walker Mary Ann Tibbetts Department of Health an Important: If item 27 is many injury or other 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jonathan Wilson, Son 156 Longview Lane, Winchester, VA 22602 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) I.O.O.F. Cemetery 7/11/2009 Elk Garden, WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility David A. Burdock Funeral Home, 21 N. Second St., Oakland, MD Katherine 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ATHEROSCUSIONC HOMES PISITASE **Physician** Y (SMY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine burial-transi and resulting in death) Last Due to (or as a consequence of) Box 68760. physician law requires that the death certificate be Physician/Medical as the l IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant. 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 mont for Day Year Month 5 Other (specify) P.O. | been signed by the should be detached 9 Illnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 JUM ENTA (IMILE 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed 1 □Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify Living 1 ☐ Yes 2 100 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To Living funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation death. neral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide hours after within 24 hours a

To the Funeral C

completely filled To the Hospital 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

10

31. Date filed (Month, Day, Year, JAN 02 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Loveria, M.D.,

(Check only one)

29b. Signature and title of certifier

Jose T.

32. Registrar's Signature

PHYSICIAN

29c. License number

912 Seton Drive, Cumberland, MD

D50844

29d. Date signed (Month, Day, Year)

July 1, 2009

21502

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-	/Medi Examir		4a. Facility Name	(If not institution	on, give street and	nu <i>mber)</i>			4b. Ci	ty, Town, o	r Location of De	_		4c. Count	y of Death	0 1
mark.			<b>CHUMPS</b>		JOOK !		npu		Ci	SM	berlo	rug		AII	ega	MY
	Funeral Director		5. Social Security 165-22-		6. Sex 1 □ M 2 🛣 F	7. Ag	je (In yrs. <b>{</b>	last birthday) <b>31</b> Yrs.	If Und Month	der 1 Year Is Days	If Under 24 H Hours M	lin. Mar	te of Birth onth, Day, Ch 4,	<sup>Year</sup> 1928	9. Birthp Cour <b>Penr</b>	place (State or Foreign offry) Sylvania
	pu »		Usual Residence of	of Decedent	,		100 0	ty, Town or Lo	nation						14	0d. Inside City Limits
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	the N	rect	10e. Street and Nu				Da.	II SDUL		Zip Code			110	0g. Citizen of	What Cour	ntrv?
	3a or	Ö	1441 Gre		e Rd.					5558				USA		,.
	72 hours after death with the Maryland natural", or items 23a or 28a-f show dieal Examinat De notlined at	Funeral Director	11. Marital Status		12. Was D	ecedent	Ever in U	.S. 13.			lispanic Origin? an, Mexican, Pu	(Specify Ye		14. Ra	ce - Americ	
98	after or ite		1 ☐ Never Mar		rried 1 □Ye	Forces? s 2 🔀 Give	No			pecify Cuba 2 <b>⊡</b> No	Specify:	ierio nicari,	etc.)	Speci	ack, White,	
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15-	n 72 l	Completed	(Spe		nt's Education est grade complete			16a. Dece	dent's U kind of I	sual Occup work done 'use retired	aation <i>during most of v</i> d)	working		16b. Kind of E	Business/Inc	dustry
212	withi jiene. r <b>thar</b>	E O	Elementary/Sec	ondary (0-12)	College	(1-4or 5	5+)	Homer			-/			Own Ho	me	
þ	other rent,	BeC	17. Father's Name	(First, Middle	, Last)			.1			18. Mother's N	Name (First,	, Middle, N	Aaiden Surna	me)	
/lar	uid be Menta Irked	P	Clyde V	. Klin	k						Elsie	A. Mi	ller			
Maryland	2 sho and Is me		19a. Informant's N	lame/Relation	ship (Type. Print)			19b. Maili	ng Addre	ess (Street	and Number or	Rural Rout	e Number,	, City or Towr	, State, Zip	Code)
	and fealth m 27 her tr	1 7			ht/Husbar	nd	1				le Rd.,			·	15558	
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedical Examinat be notified at once.	0.1	20a. Method of Dis 1 X Burial 2	•	3 ☐ Removal fro	m State		Place of Dispo cemetery, cre				Date		20c. Location	•	
Ħ	it. Pa rtmer rtant: njury		4 ☐ Donation				St				Cem. Ju					
Ba	permi Depa Impo any Ir		21. Signature of F	uneral Service	PI III	200	البر				ss of Facility ]				omes, 1536	P.A.
			23a, Part 1, Enter	the disease. o	or complications that	t caused	the deat								.1330	Approximate
	Physician		shock, or be Immediate Cause	art failure. Lis	t only one cause of	n each li	ne.	Dhit	2000	1-	0	5712	A.	t.		Interval Between Onset and Death
	/Medical		disease or conditi resulting in death	on	a	ron to (or as		uence of):	me	me	) wim	many	41.	Jane	-	( O YOU )
	Examiner					.0 (01 00	a conceq	derice on.				.0				•
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	be executed ician and burial-transit	Examiner	Cause (Disease o that initiated event resulting in death)	r injury s	c											
60,	be ex lcian a	I — I	resulting in death)	Lasi	Due	to (or as	a conseq	uence of):								
687	icate physi the b	dic			d											
Box 6	eath certificate be er attending physician for use as the burial	Physician/Medica	IF FEMALE:		23c. If yes,	outcome	of pregna	ancv				translet of	1000	224 D	ate of delive	200
	yeath atter	ciar	23b. Was deceder in the past 12 1 ☐ Yes 2	2 months?	1 Liv	e birth	2 Feta	al déath 3	Ctopic Other	c pregnanc (specify) _	У				onth	Day Year
P.O.	t the c by the achec	hysi	9 ☐ Unknowr		9 □ Ur	known										
	ires that the de signed by the a be detached to	by P	Part II. Other sign	ificant condit	ions contributing to	0+			nderlying	g cause giv	en in Part I.	23	3e. Did tob	acco use cor	tribute to th	ne cause of death?
ord	w require been si should t	ed	_ serve	16	Hartic	56	no.	515				- [	1000	s 2 □ No	3 ☐ Prob	pably 4 📉 Unknown
of Vital Records,	e law r has be	Completed										_ 24	4a. Was ar		Were auto	psy findings available mpletion of cause of
= H	t The cate h	S	la la	,								11	perform □Yes 2	ned?	death? 1 ☐ Yes	
Vita	ician sertifi ector,	Be	25. Was case refe examiner?	0 *	[11					101	26. Place of D	Death (Chec	ck only one	e)		
ot	Physician: The la rthis certificate ha ral director, page 2	은	1 Yes 2 ☐ 27. Manner of Dea	1				ER/Outpatie			4 LI Nursin			ence 6 Ot		(y)
	ding Ph h. After th funeral	ţi	1 Ratural	5 Pendi	ng (M	te of Inju onth, Da	y, Year)	Injury	' м	28c. Injur Worl	yai k? Yes 2∐No	28a. D	escribe no	w injury occu	rrea	
Division	Atten	fica	2 ☐ Accident 3 ☐ Sulcide	6 Could	not be 28e. Pla	ce of Inj	ury - At ho	ome, farm, str			163 2 1140	28f. Lo	cation (St	reet and Num	ber or Rura	al Route Number,
Ö	s after s all Dire	Certification: To	4  Homicide	deterr	bu	ilding, et	c. (Specil	(y)				Cit	ty or Town	, State)		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical (	29a. Certifier (Check only one)	1 Certifyi 2 Medica	ng Physician: To Examiner: On the	the best e basis o anner sta	f examina	owledge, deat ation and/or ir	h occurr vestigati	ed at the ti	me, date and plopinion, death o	ace, and du	e to the ca	ause(s) and n ate and place	nanner as s , and due to	stated. the cause(s)
	Fo the within Fo the comple	Me	29b. Signature and	title of certific	and III				2	29c. Licens	e number		29	9d. Date sign	ed (Month,	Day, Year)
				1	pyton	9				Poo	3324	BU		June	26	,2005
		10	30. Name and add	ress of persor	who completed ca	use of d	leath (Iten	n 23a) (Type,	Print)		Cumi			, MI	200	202N
	Sta Registr		31. Date filed (Mor	oth, Day, Year,	2009 32	Registr	ar's Signa									-

State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 26, **Physician** Shirley Weakley 2009 12:40 p.M /Medical 4a. Facility Name (If not institution, give street and number)

15 Tocati Street 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Thurmont If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days 1 □ M 2 F 66 Director 228-54-6193 Nov 4, 1942 Virginia Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10h County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Thurmont Maryland Frederick 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ö 21788 USA 15 Tocati Street Items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 6 1 ☐Yes 2 ☐No Specify: white Completed by 3 Widowed 4 Divorced 'natural", 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Education Media Assistant 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) I and 2 should be fill Tealth and Mental H Be Beatrice Nauman Carlton Lee Wilt ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a important: if item 27 is any injury or other trau once. Donald Weakley - husband 15 Tocati Street, Thurmont, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)

Leake's Chapel Cemetery 6/30/2009 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Stanley, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Sin ature of Funeral Service Licensee 1621 Opossumtown Pike, Frederick, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. THANSITIONAL CELL CANCELL OF RENAL PELVIS Immediate Cause (Final **Physician** .5 YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (us as a consequence of). Examine that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal dea 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.O. signed by the a ☐Yes 2 No 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 ☐Yes 4 1 ☐ Yes 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 201 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred After Hospital or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: d in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide n 24 hours af ie Funeral Di oletely filled ir 29a, Certifier tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated within 2 To the 29c. License number 031761 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) O'CON KB MA 501 W. SE 31. Date filed (Month, Day, 32. Registrar's Signature Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death WAS Month 2016 M **Physician** JUNE 2009 /Medical 4c. County of Death cility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner DIEN ned If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Security Number **Funeral** Months Days Hours 1 M 2 □ F 89 098-07-1154 Director June 29. New York 1919 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examinat must be rediffed at 1 Yes 2 □ No Director Coconut Creek Florida Broward 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 33066 1704 Andros Isle #K-2 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑Yes 2 ☐ No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: white þ 3 Widowed 4 Divorced Year or Dates: WW II Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Fine Paper Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Esther Kleinfield Louis Wagner ٩ 19a. Informant's Name/Relationship (Type. Print)
Doris Wagner, wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1704 Andros Isle, Coconut Creek, FL 33066 #K-2 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 07/01/09 4 ☐ Donation 5 ☐ Other (Specify) Beth David Cemetery 22. Name and Address of Facility
Torchinsky Hebrew Funeral Home 21. Si nature of Fame a Service Licensee MC1008 Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cashock, or heart failure. List only one cause in each line. NW, Washington, DC 23a, Part 1 Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Physician: The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐Yes 2 ☐ No ned by the detached Records, P.O. 9 Unknown 9 🗆 Unknown signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy certificate Division of Vital 1 🗆 Yes 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 Inpatient 2 KR/Outpatient 3 DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending vithin 24 hours after death.

To the Funeral Director: A

Completely filled in by the fi 1 ☐Yes 2 ☐No death. investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Wabner

Tanley

State Registrar

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

and address of person who completed ca use of death (Item 23a) (Type, Print) Jones

32 Registrar's Signature 31. Date filed (Month, Day, Year) JUN 29

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month **Physician** /Medical 4b. City, Town, or Location of Death nty of Death Facility Name (If not institution, give street and number) Examiner URSTNG HOME NIC M If Under 24 Hrs Date of Birth (Month, Day) Social Security Number **Funeral** Months Days Hours Min 1 □ M 2 □ XF 91 May 6, 1918 Maryland Director 217-22-6976 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importants if fleen 23s or 28s-4 show any fully or other traumatic event, the Medical Examiner must be notified at any fully or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director Stevensville MD Oueen Annes 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21666 USA 218 Olive Branch Dr. filed within 72 hours after death was spiece of the second Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. Yes 2 No Yes, Give ear or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 2 3 ₩ Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Department Store 8 Food Preparation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jeanette F. Painter James H. McKenzie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine Cook/Daughter 17015 71 Kutz Rd., Carlisle, PA Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Salisbury Cemetery July 8, 2009 Salisbury, PA 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service P.O. Box 275, Grantsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed tran and physician a the burial-1 Box 68760. Physician/Medical as attending IF FFMALE use 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Tetal death 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a detached f 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed? has page certificate 1□ Yes Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner' Other: 1 ☐ Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natura! 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

Registrar

29b. Signature and title

31. Date filed (Month, Day,

f certifier

Year)

JAUHL

30. Name and address of person who completed cause of death (Item

-8 ZUU9

M

32. Registrar's Signature

many.

DHMH 17 Rev 1/2001

29c. License numbe

29d. Date sign#d (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2009 1:30 A July C. Yoder Alvin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 287 Yoder Road Garrett 0akland Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 □ F 204-34-1284 79 Director Dec. 4 1929 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 □Yes 2 → No Director 0akland Garrett 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 287 Yoder Road 21550 United States Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dairy Farmer Farming 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kinsinger Clarence Yoder Nancy 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs. Lydia Yoder, Wife 287 Yoder Road, Oakland, MD 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 07/0372009 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gortner Amish Church Cemetery Oakland, MD 22. Name and Address of Facility David A. Burdock Funeral Home, P.A. 21 N. Second St., Oakland, MD 21550 21. Signature of Funeral Service Licensee Katherine 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Como Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter U deright Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed s certificate has irector, page 2 2□ No 1∐ Yes 1 Yes 2 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this : After thi 28a. Date of Injury 28b. Time of 27. Manner of Death 1 Natural 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division or Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: within 24 hours after death

To the Funeral Director:
completely filled in by the

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas G. Johnson, 311 N. 4th Street, Oakland, MD 21550 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

and manner stated.

29a. Certifier

29b. Signature and title of certifier

Medical

Lacritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D15333

29d. Date signed (Month, Day, Year)

July 1, 2009

			1 _ State	partment of Health and Me e <i>rtificate of Death</i>	ental Hygiene Reg. No. 2 A A A	00100
			Registrar  1. Decedent's Name (First, Middle, Last)		. Date of Death	3. Time of Death
	Physicia				June 29, 2009	5:09 P M
-	/Medic Examin		Agnes Viola Yutzy  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Dea	
-	Examini	ei	913 Springs Road	Grantsville	Garret	t
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year   If Under 24 Hrs. {	Date of Birth 9. Bir	thplace (State or Foreign
н	Director		214-52-1527 1 M 2 MF 60 Yrs.	Months Days Hours Min.	2/8/1949 Ma	ryland
	pu >		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	ogotion		10d. Inside City Limits
	aryla shov	_				1 □Yes 2- No
	he M	ect		tsville 10f. Zip Code	10g. Citizen of What Co	
	with t	흅	10e. Street and Number	21536	U.S.A.	-
	eath	era	913 Springs Road  11. Marital Status			
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Nextern Experiment must be notified at	by Funeral Director	Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 □ Yes  1 □ Yes 2 □ Yes 3 □ Yes 3 □ Yes 7 □ Ye	B. Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto R  1 □ Yes 2 ☑ No Specify:	Specify:	
Ş	tural	pa	15 Decedent's Education 16a Dec	edent's Usual Occupation	16b. Kind of Business.	
15	iin 72 n "ne n edic	Completed	(Specify only highest grade completed) (Gillife Elementary/Secondary (0-12) College (1-4or 5+)	ve kind of work done during most of working DO NOT use retired)		
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p	e filed within al Hygiene. I other than ' vent, Ire we	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (	First, Middle, Maiden Surname)	
<u>a</u>	should be f and Mental s marked o umatic eve	10	Dayton McKenzie	Virgie		Garlitz
Maryland 21215-0036	2 should be n and Mental Is marked of aumatic ev	. 3		iling Address (Street and Number or Rural		
2	1 and 2 Health :em 27 I		2,	. Box 302 Friend		
<u>o</u>	ges 1 If of F If ite or ot		20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Discemetery, cl	position (Name of Da ematory or other place)		
Ę	t. Pae tmen tant: jury	-	4 Donation 5 Other (Specify) Meadow		2009 Accident	, MD
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		Cin Medan	179 Miller St.,	man Funeral Ho Grantsville, N	
п			23a. Part 1. Enter the disease, or complications that faused the death. Do not a shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between
	Physician	i	Immediate Cause (Final disease or condition	sulmonory edes	na	Onset and Death
11.2	/Medical		resulting in death)  Due to (or as a consequence of).			
	Examiner		Sequentially list conditions, flar w leading to immediate b. Due to (or as a consequence of):			
	sit sed	Examiner	cause. Enter Underlying			
	xecul and II-tran	xan	Cause (Disease or injury that initiated events resulting in death) Last c			
9	icate be executed physician and s the burial-transit	를				
68760,		edical	d			
×	eath certific attending p for use as i		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of de	aliverv
Вох	death a atter	Physician/M	in the past 12 months?  1	B	Month	Day Year
P.0.	t the by the acher	hys	9 Unknown			
S,	w requires that the de been signed by the should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribute t	o the cause of death?
ğ	equire en siç ould b	ed t	TTN, Dreugt Concer;	Type ( Diabeles	1 ☐ Yes 2 Manno 3 ☐ P	Probably 4 ☐ Unknown
ည္မ	e law re has be e 2 sho	plet	Seizure disorde hyper	130,2len,2	24a. Was an autopsy 24b. Were a	utopsy findings available completion of cause of
Œ.	The ate h	Completed	//	,	performed? death?	
ita	iclan: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death		
<u>&gt;</u>	hysic his co		1 Maryes 2 No Hospital: 1 Inpatient 2 □ ER/Outpat		e 5 <b>V</b> Residence 6 □Other (Spe	ecify)
Ē	ding Ph After th funeral	ë	27. Manner of Death 1 ☑Natural 5 ☐ Pending (Month, Day, Year) 28a. Date of Injury (Month, Day, Year) 1 ☑Natural	Work?	d. Describe how injury occurred	
Sio	terndleath.	cati	2 Accident investigation	M 1 □Yes 2 □No		
Division of Vital Records,	arer o Direc	Certification: To	4 Homicide determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	street, factory, office	f. Location (Street and Number or Fi City or Town, State)	tural Houte Number,
_	To the Hospital or Attending Physician: The law requires that the death certifulin 24 hours are feath.  To the Funeral Director Affer this certificate has been signed by the attending completely filled by the funeral director, page 2 should be detached for use as		29a. Certifier  (Check only (Check only a part of the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or			
	To the within 2 To the I complet	Medical	one) and manner stated.  29b. Signature and title of certifier	29c. License number	29d. Date signed (Mon	ith, Day, Year)
	F ≯ F ŏ		V Malle		7/1/09	7
			30. Name and address of a rson who completed cause of death (Item 23a) (Typ	H0064705	11.10	
		3	Dr. Richard Porter MD 311 N	- 13 61 6 3	cland, MD 2155	0
	Sta	te	31. Date filed (Month, Day, Year)  32. Registrar's Signature			
	Registr	ar	.111 (11 7009   1/2	and the		

DHMH 17 Rev 1/2001

**ORIGINAL** 

Amend Item 25 per me, g894, 08/13/09dhb
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend items 16b 17 per fh g893 7-15-09 Wental Hygiene
For State of Maryland / Department of Health and Mental Hygiene

amend #19a Per FH G893 7 1 Per fine are of Death

Reg. No. 2 0 0 1 - State Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 7: 27 PM Alice **Physician** 200 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, **Examiner** The Johns Hopkins Hospital **Baltimore City** 8. Date of Birth
(Month, Day, Year)

1-2-1960 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) **Funeral** 845859 Kumasi Ghana Director Usual Residence of Deceden death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director milton Sussex )E10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number Samuel 19968 Inter Funeral Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status and 2 should be filed within 72 hours after usealth and Mental Hygiene.
m 27 is marked other than "natural", or ite Married 1 Never Married 2 No Baltimore, Maryland 21215-0036 Specify. If Yes, Give Year or Dates Specify: Black ş 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education the Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Beebe Elementary/Secondary (0-12) College (1-4 or 5+) 7. Father's Name (First, Middle, Last) 8. Mother's Name (First, Middle, Maiden Surname) other traumatic event. AdomaKoh Florence 19a. Informant's Name/Relationship (Type. Print Nsiah or Rural Route Number, City or Town, 19b. Mailing Address (Street and Number permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any injury or other trai Husbard 164 Samuel Paynter Blvd Millon, DE Augustine 2

20a. Method of Disposition

1 Burial 2 Cremation 20c. Location - City or 3 Removal from State THE CENTER S-8-2009 Rehoboth DE

22. Name and Address of Facility Vaughn C. Breune Eukeral Services 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 5151 Baltimore Nort'l Pike Balto. mb 21229 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 10 morrhage rouran **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ROVED BY MEDICAL Examiner DAY, NO YOU GO IN ROTHING HIS RESULT. The law requires that the death certificate be executed CERTIFICATION and the burial-trai Due to (or as a consequence of) resulting in death) Last Box 68760. physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No Day Pregnant at time of death 5 Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð Division of Vital Récords, be 2 No 3 Probably 4 Unknown 1 Yes Completed phone 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 page 2 s After this certificate has 2 🗌 No 1 Tyes 1 Yes Physician; 25. Was case referred to medical 26. Place of Death (Check only one) director. Be examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred the funeral Certification: 1 Natural 2 Accident 5 Pending investigation Injury or Attending 1 🗌 Yes 2 🗌 No death. after death Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide the Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only one) completely and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RES-000 J000 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 600 North Wolfe St, Baltimore, MD, 21287 Mancu 31. Date filed (Month, Va.), Year) **JUL 15 2009** 32. Registrar's ignatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-05240 State of Maryland / Department of Health and Mental Hygiene Douglas Askins 1- For State Certificate of Death Registrar 2. Date of Death Time of Death Decedent's Name (First, Middle,Last) Physician/ Month D July 3, 2009 Year 1626 hrs Medical Examiner Askins Douglas 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** N/A 2821 Round Road If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Hours Min Months Davs Director 3/1/1950 Country) MD1 XM 2 F 216-50-4405 59 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1X Yes 2 No s 23a or 28a-f show e notified at once. Baltimore Pages I and 2 should be filed within 72 hours after death with the Maryland rett of Health and Mental Hygiene.

If Titlen 27 is marked other than "maryland other traumatic even." N/AMD 10g. Citizen of What Country 10e. Street and Number USA 21225 2821 Round Road 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married Married Yes Specify: Black Yes 2X No specify: If Yes, Give Year Widowed Divorced 2 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Salvation Army Driver 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Annie Askins Be <u>Ask</u>ins Talbert Α. (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 212251200 Cherryhill Rd-B, Baltimore, Annie Askins 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition timore, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 7/10/2009Lansdowne, Md. Mt.Zion Cemetery Other Specify Donation 5 ESTER AROTHERS Funeral Service, re of Funeral Service Licensee Signat 21217 1300 Eutaw Place, Baltimore, Approximate Interval To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart cations that caused the death Between Onset and **Physician** failure. List only one cause on each line Death **Medical** a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be executed and trai sician/Medical AMENDED UNPENDED attending physician or use as the burial Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: Day 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Fetal death Live birth past 12 months? Pregnant at time of death 5 Other (Specify) the death 1 Yes 2 No 9 Unknown Unknown Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o that No 3 Probably 4 ✔ Unknown by Yes 2 σ. Completed ficate has been s , page 2 should b 24b. Were autopsy findings available 24a. Was an Records, prior to completion of cause of autopsy performed? death? Yes 2 ✔ No Yes certificate 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical Be of Vital Other<sub>4</sub> Hospital: 1 Residence 6 V Other: Scene Nursing Home 5 ER/Outpatient 3 Inpatient this 1 Yes No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year 28b. Time of Injury After 27. Manner of Death Certification: 1 V Natural Yes 2 No Division Pending Director: Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) Suicide determined To the Funeral Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 10, 2009 O.C.M.E. DOME 30. Name and address of person who completed caus of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Theodore M. King, Jr., MD. 31. Date filed (Man Registrar's Signa State Registra

Division or Vital Records, P.O. Box 68760,

	-	For State Registrar		Sta	ite of	f Maryla			rtment of tificate of				giene Reg. No	e .20	09	224	65
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Examine		4a. Facility Name (/		n, give street a	and nun	nber)			4b. City, Town,		of Death		40		y of Death		
		5410 TOD		6. Sex		7. Age (In yr	s last hirth	nday)	BALTIM If Under 1 Year		r 24 Hrs.	8. Date of Bir	th		/A 9. Birth	place (State or	Foreian
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permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any Injury or other traumatic event, the Medical Exagnoe.		21. Signature of F	uneral Service	Licensee					Name and Add		MIL.					L HOME,	INC.
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could deterr		e. Place buildi	of injury - At ing, etc. (Spe	home, far c <i>ify)</i>	m, stre	eet, factory, offic	е		28f. Location City or To			nber or Ru	ral Route Numb	ber,
spital ours a neral C		29a. Certifier	1 X Certifyi	ng Physiclan	: To the	best of my k	nowledge	. death	occurred at the	time, date	and place.	and due to th	e cause	(s) and	manner as	stated.	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TTEM#26, perPHYS, G893, 7/15/09, WS
State of Maryland, Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician BARIVES 8:55 A. M Ju<sub>1</sub>v 2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Tate Hospice House Linthicum Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months Days Hours 1 ☑ M 2 □ F 83 219 18 3372 10/04/1925 Maryland Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 X No Linthicum Maryland Anne Arundel Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21090 U.S.A. 531 Cleveland Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examines 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Coca Cola Trucker 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Barnes Mary Kruth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 531 Cleveland Road Linthicum, Maryland 21090 Minnie Barnes / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 A Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 07/03/2009 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licenses 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1, offer the disease, for implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. Let only one cause on each line. ANLER OF THE KIDNEY Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Vear in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ CANCOR OF BLADOOR. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed DIARBRET MELLTIVS PUPEL 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home Thesidence 6 Nother (Specify House Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D21336 09 d address of person who completed cause of death (Item 23a) (Type, Print)

LSIN D. KNHN J. MD. BOZB RITCHIE HIGHWAH, PASADOWA, MD ZVI 22

(Month, Day, Year)

32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 26 per doc 9893 7-15-09 vt State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 1647 2009 Mildred Edwina Blake July 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore 2636 Quantico Avenue If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year) Months Days 1 □ M 2 🖵 F Yrs. 51 11 1958 Maryland Director 212-74-3632 Apr. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location show 1 ∑Yes 2 □ No N/A Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 21215 USA 2636 Quantico Avenue Funeral Pages 1 and 2 should be filed within 72 hours after death onent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Spe Bylack ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Frederick Douglass Elementary/Secondary (0-12) College (1-4or 5+) Custodian High School If item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lemuel Blake Elnora Oliver 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2636 Quantico Avenue Baltimore, Maryland Elnora L. Randall/ Sister injury or other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 7/13/09 Mt. Zion Cemetery : Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, Md 21215 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or h, art failure. List only one cause on each line. poven Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine 201 burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) P.O.1 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed: 1 ☐ Yes 2 ☐ No 2 🗆 No Division of Vital 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🗷 Residence 6 🚾 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To funeral 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28h. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0054836 7,9.09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NALAY INI SIVARAM AW Parkteights the 340 Balt no 21215

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) \_

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Philomena Anna Brown 8:55 2009 July 10, 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street end number) Baltimore Perry Hall 9707 Bernard Lewis Court If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours 1 □ M 2 🗓 F 85 218-22-5130 Aug. 13, 1923 Maryland Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2X No Perry Hall MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21128 USA 9707 Bernard Lewis Court 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Maritai Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married white 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) At Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Lanesi Frank Babusci 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores Rockstroh-daughter 9707 Bernard Lewis Court-Perry Hall, Maryland 21128 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 15,2009 Timonium, Maryland Memorial Garciens 21. Signature of Funeral Service Licensee 3 Newport Drive EVANS FUNERAL AND CREMATION CHAPEL SERVICES Forest Hill,MD 21050 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death immediate Cause (Final disease or condition resulting in death) month Due to (or as a consequence of): Sequer tially list sorrollions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):

**Physician** /Medical **Examiner** 

permit. Page Department of Important: If any Injury or once.

Physician

/Medical

Examiner

**Funeral** 

Director

28a-f sh notified

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r than "natural", or items 23a the Medical Examiner must t

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene, and the than "natural", or ite marked other than "natural", or ite ury or other traumatic event, the Medical Examine ury or other traumatic event, the Medical Examine

Baltimore, Maryland 21215-0036

Director

Funeral

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Be Completed

with the Maryland

death v

Examiner attending physician and for use as the burial-tran Physician/Medical þ Completed Be ဥ I Director: After to in by the funera Certification: within 24 hours aft

To the Funeral Di

completely filled in Medical

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

	d								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	al death 3 □ Ectopic				-	23d. Date of de Month	elivery Day	Year
Part II. Other significant conditions of Demen Hg	Anxiety	ulting in the underlying	g cause	given in Part I.		217	use contribute t	/	e of death? 4 ∐Unknown
Type 2 Diable Hypertension	etes Melliti	15			24a. Wa au pe 1∐ Yes	rtopsy erformed	prior to death?	completion	ings available of cause of
25. Was case — ferred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□	DOA (	26. Place of De Other: 4□ Nursing I	-	one esidence	6 □Other (Sp	ecify)	
27. Manny of Death 1 Vatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M		njury at Work? 1 □ Yes 2 □ No	28d. Describ	e how inj	ury occurred		
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At he building, etc. (Specific	ome, farm, street, fact fy)	tory, offi	ce		n (Street a Town, Sta	and Number or F ate)	Route	Number,
	ysician: To the best of my kno niner: On the basis of examina end manner stated.								use(s)
29b. Signature and title of certifier			29c. Lic	ense number		29d. D	Date signed (Mor	nth, Day, Ye	ar)

DHMH 17 Rev 1/2001

State Registrar 21284

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Year) 2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month Day Year 16:56 M 2009 Catherine Bonner /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner USA Samaritan Baltimore HOSPITA Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Min Months Days Hours 1 □ M 2 □ F Director Virginia Mar 15, 1930 215-22-7799 79 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 □ No Director Baltimore N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with U.S.A. 21213 3222 Chesterfield Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. 9 Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other that any injury or other traumatic event, Its once. Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Beatrice White Allen White ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3222 Chesterfield Avenue Baltimore, Maryland 21213 Carolyn Bonner 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 → Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 07/18/09 Baltimore, Md. Western Cemetery 21. Sign-sure of Funeral S vix Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** Diratory Fai Hyperces /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an cate has autopsy performed?

1 □ Yes 2 ☑ No certificate the Hospital or Attending Physician: this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death | Director: d in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-00 METUUCCI, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARIA B. HENUCCI - 600d Samaritan Hospital - 5601 Upch Rayen Blvd - Baltimore - 21239 - Haryland - USA 32. Registrar's gnature State

Registrar
DHMH 17 Rev 1/2001

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21215-0036

Maryland

Baltimore,

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) BARNES **Physician** 200 VIA /Medical 4c. County of Death 4b. City, Town, or Location of Deat Name (If not institution, give street and number, Examiner andall evi all Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 Maryland 7. Age (In yrs. last birthday)
Yrs. If Under Date of Birth (Month, Day, 5. Social Security Number **Funeral** Year Months Days Hours Min. M 2□ F Mar 5, 1928 220-20-1304 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10b. County 10c City Town or Location r 28a-f show notified at show 1 Yes 2 No Baltimore Baltimore Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Items 23a or 2 iner must be n 21207 U.S.A 6833 Windsor Mill Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11 Marital Status Black, White, etc. the Medical Examiner Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 X Married 5 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify: Specify **Black** þ 3 ☐ Widowed 4 ☐ Divorced 'natural', Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Bakery College (1-4or 5+) than Elementary/Secondary (0-12) Baker other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ith and Mental F
7 Is marked ot traumatic even Augusta Palmer Arthur Barnes 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1104 Stoddard Court Baltimore, Maryland 21201 t of Health a Rosa Barnes Department of Health Important: If item 27 any injury or other tronce. 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 Removal from State 07/15/09 Catonsville, Maryland Metro Crematory, Inc. 5 Other (Specify) 4 Donation 21. Signatury of Funeral Service Linensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. 1300 Eutaw Place Baltimore, Md 21217 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. enter the mode or dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy pertormed certificate 1 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA မှ 1 ☐ Yes 1 🗌 Inpatient 28a. Date of Injury (Month, Day 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 5 ☐ Pending investigation 1 Natural 1 Yes 2 No death. neral Director: / 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

31. Date filed (Month, Day,

15 20

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Rea. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 9:29 PM Bond nota ius /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore baltimore MO 9. Birthplace (State or Foreign 8. Date of Birth Month, Day Year 02/10/1922 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Sex 1X M 2□ F . Age (In yrs. last birthday, **Funeral** Country) Min 87 Vrs 214-01-9678 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 273 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is the lies Exemples must be notified as 1 ☐ Yes 2 X No Director OWINGS MILLS BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21117 USA 8002 C TOWNSHIP DRIVE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1**Y**Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 □Yes 2X No Specify. Specify: WHITE \$ 3 N Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED MENS CLOTHING 12 should be filed with and Mental Hygier 7 Is marked other the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SARAH **GELTMAN** FRANK BONDROFF ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BARRY BONDROFF / SON 8313 MEADOWSWEET ROAD, BALTIMORE, MD Pages 1. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State 107/14/2009 REISTERSTOWN, MD OHEB SHALOM MEMORIAL 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature Fineral Service License 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final eak Physician vale disease or condition resulting in death) /Medical Due to or as consequence of): Examiner Equentiary list or official, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transi and Due to (or as a consequence of) Box 68760, physician pe Physician/Medical the attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) signed by the a P.0. 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 2 No 3 Probably 4 Unknown icate has been sig , page 2 should b 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2/2/10 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 1 Yes 2 No Hospital 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Qther (Specify) Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 X ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0068286 WD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) West Tormsontonn Blod, Baltimore, MD 21204 31. Date filed (Month, Day, Year) --State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 30 /Medical 4a. Facility Name (If not institution, give street and number) Examiner Birthplace (State or Foreign 8. Date of Birth Social Security Number Sex 1/□ M 2□ F 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 79/1930 212-28-0009 78 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Tre Medicel Extra vilver meat be notified at once. 1 ☐ Yes 2X No Director RANDALLSTOWN MD BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21133 9 BURR OAK COURT Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ NA RMY If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) SURGEON MEDICINE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LOUIS **BERMAN** FANNIE ROSENFELD ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) SHARON C BERMAN / WIFE 9 BURR QAK CT, RANDALLSTOWN, MD 21133 20b. Place of Disposition (Name of MI KROET KODESH or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) BETH ISRAFL CONG. 07/ 22. Name and Address of Facility 07/14/2009 BALTIMORE. SOL LEVINSON & BROS., signature of uneral Servi 8900 REISTERSTOWN RD., PIKESVILLE, MD 21208 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (c. as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) signed by the a d be detached fo ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown this certificate has been sal director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 □No 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 □Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tiple of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Northwest 14

State

Registrar

09-05423 Kevin Blair, Jr Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2009 22473

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Physiciar ' 'Examin	n/ 1	egistrar . Decedent's Name (First, Middle,	Last) Kev	in Bla	ir, J				Date of Death  Month  Date  Da	ay Year	0303111	
, *		a. Facility Name (if not institution			4	b. City, Towr Aberdee		n of Death		Harford		
Funeral Director	5	5. Social Security Number	6. Sex <b>XX</b> M 2 F	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Months	Year If Ur Days Hou		8. Date of Birth(I		Foreign	or ID
		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Locati	on					10d. Inside	City Limits
with the Maryland ms 23a or 28a-f show any be notified at once.	ter	Md N	I/A 	Balt	imore	10f. Zip Co	ode			. Citizen of Wh		
th the Mar 23a or 28 notified a	Dire	6008 Twilight		cedent Ever in U.	S. 13. Wa	2120	of Hispanic (	Origin? ( Spe	ecify Yes or No-		e - American Indian, E	Black,
er death w	Fune	1 Never Married 2 X Ma		orces?	1	es, specify C	No spec	cify:		Specify:	Black	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. I tant: If item 27 is marked other than "natural", or items 23a or 28a-f she other traumatic event, the Medical Examiner must be notified at once or other traumatic event, the Medical Examiner must be notified at once	eted by	15. Decedent's Education (Spec Elementary/Secondary (0-12)		nde completed) 1-4 or 5+) N/A		nt's Usual Oc lost of working Stant	ng life. DO N	OT use retir	ork done ed)	Walma	usiness/Industry	
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	$\sim$ 1	12th grade 17. Father's Name (First, Middle,		N/A			18.Mo	ther's Name	(First, Middle, Ma	aiden Sumame	e)	
2121 ould be fil Mental I marked ic event,	Be	Kevin Blair, 19a. Informant's Name/Relations	hip (Type, Print )		19b. Mailin	g Address	(Street and	Number or F	Rural Route Numb	per, City or Tov	wn, State, Zip Code)	
AD 2 2 shoul 1 and N 27 is n imatic	2	Shana Blair-			6008	3 Twil	ight (	Court	Balto,	MD 212	206 - City or Town, State	
Baltimore, MD 21215-003 pernit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thingury or other tranmatic event, the Med		-23	n 3 Removal	from State G	Place of Dispo crematory or o arden	ther place). of Fai	th	7-1	.6-2009	Balto	Co, MD	
altin mit. Pa partmen portan	0	Donation 5 Other S  21. Signature of Funeral Service	Licensee		\				rch East	F/H	MD 21202	1
		23a. Part I. Enter the disease, o	complications that	caused the death	Do not enter	the mode of	dying, such	as cardiac o	respiratory arre	st, shock, or h	eart Approxim	nate interva
Physician ledical .aminer		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	e on each line. e a. <mark>Head Inju</mark>								Joines,	Death
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		s a consequence	of):							
ecuted and - transit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to for a									
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f Vital Records, P.O. Box 68760,  Physician: The law requires that the death certificate be executed er this certificate has been signed by the attending physician and aral director, page 2 should be detached for use as the burial - transi		IF FEMALE: 23b. Was decedent pregnant in past 12 months?	the 1 Liv	es, outcome of pre e birth egnant at time of o	2	Fetal death Other (Spec		ctopic pregn	nancy	Month		Year
that the death certif ned by the attending detached for use as	P H			known g to death but no	t resulting in th	e underlying	cause giver	in Part I.			ontribute to the cause	
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ecol he law ite has									1 🗸 Yes	ormed? 2 No	1 Yes	2 No
/ital Rec ysician: The l his certificate l director, page	B O	OF Was case referred to medi	cal Hospital:		50/0 4-4			Death (Chec	k only one)	Residence	6 Other: Scene	
Division of Vital Records, tal or Attending Physician: The law requinant and and reach.  The procedur. After this certificate has been steen in by the timeral director, page 2 should to		1 Yes 2 No	28a. D	Inpatient 2 date of Injury lonth, Day Year) 1, 2009	28b. Time 0243 hrs	of Injury	28c. Injury a			how injury oc		
Division O' To the Hospital or Attending within 24 hours after death To the Funeral Director: After Completely filled in by the fune	Certification	1 Natural 5 Pe 2 V Accident In 3 Suicide 6 C	ould not be	Place of Injury - A		treet, factory	, office build	ling, etc.	28f. Location or Town, I-92 N/B MN	(Street and No State) 183.1, Abero	umber or Rural Route	e Number, C
To the Hospital within 24 hours a To the Funeral Completely filled			Physician: To the	best of my know		ccurred at the	e time, date y opinion, de	and place, a	and due to the cau d at the time, dat	use(s) and ma e and place, a	nner as stated nd due to the cause(	(s)
To the To the Come	Modical	29b. Signature and title of cer	and main	ner stated			c. License n	umber		29d. Date	signed (Month, Day	Year)
		auesz					O.C.M.	E.		July 11	, 2009	
61		30. Name and address of personal Rubio MD.	Assistant Medic	cal Examiner	111 Pen	n Street,		e, MD 212	201			
~	Stat	e 31. Date filed (Month, Day, Ye	ark 2000 3	2. Registrar's Sig	nature	back						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 13 4135 AM **Physician** BONACCI 200 ERNEST VICITOLAS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, **Examiner** 08 NIA Himore Buttimore Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days 1 M 2 F 1928 PENNSYLVANIA E JUNE 1 20 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be retified at 1XYes 2 □ No Directo CARROLL **ELDERSBURG** MO 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21784 USA SERRA DRIVE 20 KUNY Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
15(Yes 2 No 950)
If Yes, Give
Year or Dates: 195 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No and 21215-0036 Specify. Specify: WHITE Completed by 1952 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) SOCIAL SECURITY College (1-4or 5+) Elementary/Secondary (0-12) AUMINISTRATION ANALYST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be Health and Mental BONACCI 11 CHOLAS CATHERINE MOLINARO ၉ Baltimore, Maryl 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21784 19a. Informant's Name/Relationship (Type. Print) UDREY ELDERSBURG-MO BONACCI 2031 RUDY SERRA DRIVE Important: If item 27 any injury or other tr WIFE 20 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages ' 1 Burial 2 ☐ Cremation 3 ☐ Removal from State SYKESUILE, MD 4-16-2009 AKE VIEW MemoPK 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility N ZUMBNW FH & MON CO 21. Signature of Funeral Service Licensee SYKESVILLE RO ELDERSBURG MO 21784 6028 Pan 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** tensià /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-tran and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ZNo P.O. been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe certificate 1 ☐ Yes 2 ☐ No of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Scrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) 75 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 19b per inf. 9893.07/31/09dhb

Amend Items 1,19a per inf. 19 1 - For State Registrar Reg. No.- U 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** July 9, 0534 Milton John Barnes Jr. 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Hospital Cheverly Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/14/1931 Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 ☑ M 2 🗆 F Months Days Hours Min. DC **Director** 77 578-42-8347 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at 1 X Yes 2 □ No Director MD Prince George's Largo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with USA 500 North Harry S. Truman Dr. 20774 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iten any injury or other traumatic event, the Modical Evantine once. Black, White, etc 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: Black δ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) IBM Corporation 6 years Senior Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ Cecelia Jones Milton J. Barnes Sr. 19a Informant's Name/Relationship *(Type Print)* Gloria L. Barnes — wife Martin Barnes/son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
500 N. Harry S Truman Dr. #327, Largo, MD 20774
508 68th Place Seat Pleasant, MD 20743-Gloria Martin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/14/2009 Gate of Heaven Cem. Silver Spring, MD 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licenses 23a. Path. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4217 9th St NW Washington DC 20011 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Fatal Cardiac Arrhythmia Medical Due to (or as e consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, <u>۾</u> 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were eutopsy findings available prior to completion of cause of death?

1 □Yes 2♣️No 24a. Was en within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. autopsy 2XXVo 1 ☐ Yes Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No ER/Outpatient 3 ☐ DOA ဥ 1 Inpatient 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospital or To the Hospital within 24 hours a To the Funeral L 29a. Certifier \*\*Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D. 3001 Hospital Drive Cheverly, MD. Nicole Richardson, M, 20785 31. Date filed (Month, Day Year) **JUL 15 2009** 32. Registrar's Sigeature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh g894 8-25-09 vt State of Maryland? Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 16:41 PM Month **Physician** Buschman Z009 Tohn /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore VA Medical Center If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Moth Day, Year) 5. Social Security Number 6 Sex **Funeral** 1 ₹ M 2 ☐ F Maryland May 21. 217-12-9676 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, fro Medical Evanteer must be notified at 1 ☐Yes 2 ▼No Completed by Funeral Director Towson Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21286 Apt 402 204 East Joppa Road, 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Dyes 2 No If Yes, Give 1943-1966 Year or Dates: 1 ☐ Never Married 2 ▼ Married 1 ☐ Yes 2 ☐ No Specify: Maryland 21215-0036 Specify: WHite 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4or 5+) Air Force Officer 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ertel Josephine Buschman John George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21286 19a. Informant's Name/Relationship (Type. Print) Apt 402 Towson, Maryland 204 East Joppa Road, <u>Margaret K. Buschman</u> Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cametery, crematory or other place)
Ar Ington Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-1-2009 Arlington Virginia Cemetery National 21. Signature of Figure Service Litensee Ruck Towson Funeral Home, Inc. 22. Name and Address of Facility Towson, Maryland 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Pheumonia Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): 1 Week Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Division of Vital Records, ģ 2 No 3 Probably 4 Unknown Deural effusion 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Aortic Stanosis autopsy performed? 2 No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural Certification: Hospital or Attending 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide To the Hospital or within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Hvano 18965 10 N. Greene Street. Baltimore MD 2/201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hwana , MID.

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

32. Pegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 23 PI Line a Garyland Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** /Medical 4a. Facility Name (If not institution, give street and number, 4h. City. Town, or Location of Death 4c. County of Death Examiner 2002 Paulette Road Dundalk Balto If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Davs Hours Min. 1 □ M 2 X F 214-22-1582 2-22-1922 N.C. Director 87 Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location an "natural", or items 23a or 28a-f show Medical Examinational be notified at 1 ☐ Yes 2√ No Director Balto Dundalk 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2002 Paulette Road USA 21222 by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Black 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) unk r than " College (1-4or 5+) Elementary/Secondary (0-12) Nurses Aid 7 is marked other traumatic event, II 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nancy Whitfield James Spivey ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr. once. Patricia Williams-Daughter 2002 Paulette Road Dundalk, MD 21222 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-15-2009 Balto, MD St Stanislaus Cem 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March East F/H Balto, MD 21202 1101 E. North Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ) ane Approximate Interval Between Onset and Death Immediate Cause (Final udden rdiar **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Myocardial infarction Sequentially list conditions, if any, leading to intrincipal cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). To the Hospital or Attending Physician; The law requires that the death certificate be executed Exami Coronary artery disease physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 □ No the 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has but director, page 2 sl autopsy 1 ☐ Yes 2 12 No 1 □Yes 2 □No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this within 24 hours after death.

To the Funeral Director; After the 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature, and title of certifier 30. Name and address of person who completed cause of care 31. Date filed (Month, Day State 15 2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-05410 State of Maryland / Department of Health and Mental Hygiene Betsy W. Cremeans Certificate of Death Reg. No 1- For State 2. Date of Death Registrar Month Day July 10, 2009 1. Decedent's Name (First, Middle, Last) Physician/ 0634 hrs Medical Examiner BETSY W. CREMEANS 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** Rosedale Franklin Square Hospital 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Funeral Months Days Hours Min WEST VIRGINIA DEC. 22,1929 Director 79 Yrs M 2X F 222-16-4415 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 Yes 2 XNo s 23a or 28a-f show e notified at once. DUNDALK BALTIMORE permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the <u>Medical Examiner must be notified</u> at once. 10g. Citizen of What Country? Director 10f. Zip Code 10e. Street and Numbe USA 7801 PENINSULA EXPRESSWAY APT 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-12. Was Decedent Ever in U.S. Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married WHITE 2 X No Yes Specify. Yes 2 X No specify: Divorced If Yes, Give Year 3 XWidowed 16b. Kind of Business/Industry ð 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) NURSING HOME 21215-0036 2 NURSE 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CORA MCGHEE Be ARTHUR ROSS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 2 BALTIMORE, MD 21214 8 3115 TYNDALE AVE CHARLOTTE KEHNE-DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State BALTIMORE, MD 7/14/09 OAKLAWN CEMETERY Donation 5 Other Specify 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 21. Signature of Funeral Service Licensee 6224 EASTERN AVE BATLIMORE, 23a. Part I. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and **Physician** Death a. Pulmonary Thromboembolism due to deep leg vein thrombosis 'Medical Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical physician a AMENDED UNPENDED 23d. Date of delivery The law requires that the death certificate be Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: Day Year Month 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth 2 past 12 months Pregnant at time of death Other (Specify) 5 1 Yes 2 ✔ No 9 Unknown Unknown signed by the a 1 be detached fo 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions P.O. 1 Yes 2 ✓ No 3 Probably 4 à 24b. Were autopsy findings available 24a. Was an Completed ficate has been s , page 2 should b Records. prior to completion of cause of autopsy death? performed? certificate has 1 🗸 Yes No ✓ Yes 2 26. Place of Death (Check only one) To the Hospital or Attending Physician: 'within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medical of Vital director Be Other-Hospital: 1 Residence 6 Other DOA Nursing Home 5 2 V ER/Outpatient 3 Inpatient No 1 V Yes 28d. Describe how injury occurred 28c. Injury at Work? funeral 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: Yes 2 No 1 V Natural Division Pending neral Director: A 28f. Location (Street and Number or Rural Route Number, City 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) Could not be 3 Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely cal and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b Signature and title of certifier July 11, 2009 O.C.M.E. ene ne 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Margarita Korell MD 32. Registrar's Sig 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 15:09 PM 2009 Cupriotis 4 Barbara Julu /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Battimore Johns Hopkins Bayview Medical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 07/18/1949 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Number **Funeral** Days Hours Months Min. 213-52-5615 1 ☐ M 2 💢 F 59 MD. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10h. County 10a. State show If is marked other than "natural", or items 23a or 28a-f shor traumatic event, the "Modical Eventher in the Contines at 1 √ Yes 2 No Director N/A MD. BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES 620 SAVAGE STREET 21224 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 📆 No Specify Specify: WHITE Completed by 3 ☐ Widowed 4 🙀 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 9TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental I is marked of es 1 and 2 should be of Health and Ment item 27 is marked DONALD ANDERSON HELEN ANDERSON ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) HELEN MORRIS/DAUGHTER 811 NORTH AVE. I, CROWLEY, LA 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 permit. Pages Department of Important; If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/10/09 ATLANTIC CREMATORY GLEN BURNIE, MARYLAND 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 21. Signature of Funeral Service License 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Liet only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 36 hours Physician Sepsis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed as the burial-transit and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Month Year Day 5 Other (specify) signed by the a d be detached for ☐Yes 2☐No Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown this certificate has been s al director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 Yes funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 ☑ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred after death.

I Director: After do in by the funers 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State Registrar 29b. Signature and title of certifier

Kvistina Frogale
31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

4940 Eastern Avenue, Baltimore, MD 21224

RES-000

29d. Date signed (Month, Day, Year)

July 4, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

SIMARON ROSE CZYZENSKI  BALTIMONE WASHINGTION MEDICAL CENTER  CLIN BURNI E  CLIN BURNI	Decedent's Name	(First, Middle,	Last)			rtifical				2. Date of I			Year	3. Time of	Deatl	
BALT HORE WASH INCTON MEDICAL CENTER  CICH SURVEY    Comparison of Charles   C	SHARON RO	SE CZYZEV	VSK1									-	rear	1324	P	
Control   Number   Control   Contr	. Facility Name (If	not institution,	give street and nur	mber)		4b. City,	Town, or	Location	of Death		4	4c. County of Death				
Table   Tabl									Od Uro I							
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A CREATE HUSBAND  7512 B&A BLVD. CLEN BURNIE, MD 21060  20c. Location - City or Town, State Centre of Date Comments of Date Comments of Centre of Date Centre of Centr		me/Relationshi			19b. Maili	ing Addres	s (Street a			al Route Nui	mber, City	or Town,	State, Zij	p Code)		
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in the past 12 months? 1   yes 2   No 9   Unknown   9   Un						□ Estania	nragnone	,								
Surt II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   CIRRHOS   Surprise   CIRRHOS   Surprise   CIRRHOS   Surprise   CIRRHOS   Surprise   CIRRHOS   Surprise   Sur	in the past 12, 1 □Yes 2 □	months?	4 ☐ Pregi	nant at time of d				y			-	Мо	nth	Day	Year	
PORTAL HYPERTENSION  24a. Was an autopsy performed? 1   Yes   2   No   3   Probably   4   Unknown   24b. Were autopsy findings availy preformed? 1   Yes   2   No   25c. Was case referred to medical examiner? 1   Yes   2   No   25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Was case referred to medical examiner? 25c. Place of Death (Check only one)  25c. Place of Death (Check only one)  25c. Place of Death (Check only one)  25c. Injury at   Work?   28d. Describe how injury occurred  25c. Injury at   Work?   28d. Describe how injury occurred  25c. Injury at   Work?   28d. Describe how injury occurred  25c. Injury at   Work?   28d. Describe how injury occurred  25c. Injury at   Work?   28d. Describe how injury occurred  25c. Injury at   Work?   28d. Describe how injury occurred  25c. Injury at   Work?   28d. Describe how injury occurred  25c. Injury at   Work?   28d. Describe how injury occurred  25c. Injury at   Work?   28d. Describe how injury occurred  25c. Injury at   Work?   28d. Describe how injury occurred  25c. Injury at   Work?   28d. Describe how injury occurred  25c. Injury at   Work?   28d. Describe how injury occurred  25c. Injury at   Work?   28d. Describe how injury occurred  25c. Injury at   Work?   28d. Describe how injury occurred  25c. Injury at   Work?   28d. Describe how injury occurred  25c. Injury at   Work?   28d. Describe how injury occurred  25c. Injury at   Work?   28d. Describe how injury occurred  26c. Place and place, and due to the cause(s) and manner as stated.  26c. Place and place, and due to the cause(s) and manner as stated.  26c. Place and place, and due to the cause(s) and manner as stated.  26c. Place and place, and due to the cause(s) and manner as stated.  26c. Place and place, and due to the cause(s) and manner as stated.  26c. Place and place, and due to the cause(s) and manner as stated.  26c. Place and place, and due to the cause(s) and manner as stated.  26c. Place of Injury at   Work?   1   Yes   2   Yes   Yes   Yes   Yes										00 -	dal Ac-E		db. /t- :	the e	de: "	
PORTAL HYPERTENSION  24a. Was an autopsy performed? 1   yes   2   No   2   No   2	_		ns contributing to de	eath but not resu	ulting in the u	underlying	cause give	en in Part	I.		,					
autopsy performed?	CIKKHU515	)				****					∐ Yes	1				
5. Was case referred to medical examiner?  1	PORTAL HY	PERTENS I	ON							a	utopsy	F	prior to co	opsy findings ompletion of c	avai aus	
examiner?  1   Yes   2   No												No S		2 🗆 No		
7. Manner of Death 1 Manual 2 Accident 3 Suicide 4 Homicide  28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No  28d. Describe how injury occurred  2	examiner?		Hospital:				Oth	Dr.								
1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28f. Location (Street and Number or Rural Route Number, Cit			1 1 1				OA	4 🗆 🗅	lursing Ho					ify)		
28e. Place of Injury - At home, farm, street, factory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28e. Place of Injury - At home, farm, street, factory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28e. Place of Injury - At home, farm, street, factory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)  29a. Certifier (Check only one)  29d. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	1 X Natural	5 Pending	(Mon	th, Day, Year)	Injury				]No		20 HOW III	, a. , 000011				
Ba. Certifier (Check only one)  Diagram: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  Diagram: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  Diagram: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Diagram: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Diagram: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Diagram: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Diagram: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Diagram: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	3 🗌 Suicide	6 ☐ Could no	ot be 28e. Place	of Injury - At ho	me, farm, st	1							er or Rui	ral Route Nun	nber,	
(Check only one)  2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  3b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  7/2/09  3b. Name and address of person who completed cause of death (Item 23a) (Type, Print)	4 ☐ Homicide	deterrilli	buildi	ng, etc. (Specif)	y)					City or	rown, Sta	ate)				
29c. License number 29d. Date signed (Month, Day, Year)  D43623 7/2/09  Name and address of person who completed cause of death (Item 23a) (Type, Print)			xaminer: On the b	asis of examina											s)	
). Name and address of person who completed cause of death (Item 23a) (Type, Print)	9b. Signature and	title of cortifier		N.		29	9c. Licens	e number			29d. [	Date signe	d (Month	, Day, Year)		
). Name and address of person who completed cause of death (Item 23a) (Type, Print)		PR	mm	MM			D4352	3			7/2	/09				
ERIK L. RUSSELL, M.D. 7711 QUARTERFIELD RD. SUITE A, GLEN BURNIE, MD 21061	15.6							-			1,72					
	). Name and addr	ess of person v	vho completed caus	e of death (Item	n 23a) (Type	e, Print)										

Sta

Registrar

Physicia /Medic Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Modical Examinational benefited at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) July 13<sup>y</sup> 2009 **Physician** 11:45 Nelson Crusse рм Clarence /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Pikesville 225 Sudbrook Lane 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept 24 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** Min. Days 1**X** M 2□ F Months Hours 69 1939 Director 218-36-1253 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Maryland Emist be notified at any injury or other traumatic event, If a Maryland Emist be notified at appear. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No Director Baltimore Pikesville Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 225 Sudbrook Lane 21208 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 x Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Business Owner Beautician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Virginia White John Crusse Mary Clarence -ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 225 Sudbrook Ln. Pikesville, Md. 21208 Mr. Daniel Weinstein/ Companion 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 7-15-09 Hilltop Service Co. Towson, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 23a. Part 1. Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
U Month S Immediate Cause (Final Physician Mepatocellular disease or condition resulting in death) /Medical Due to her as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Year 5 Other (specify) signed by the a ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performs eral Director: After this certificate filled in by the funeral director, pag 1 ☐Yes 2 ZNo 1 ☐ Yes 2/DNO Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA မှ 1 🗀 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) Oncologist 29c. License number 00056919 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Donegan, MD. GBMC West Pavilion Ste. 205 Baltimore, Md. 21204 31. Date filed (Month, Day, Year) State Denve S. face Registrar

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ORIGINAL

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State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	Otate of Mary			ificate of L			Reg. No. 2	009	22482
	Physicia	an	1. Decedent's Name (First, Middle, La	st)	Ric		25.0	Da. 000	2. Date of De Month	ath Day	Year	3. Time of Death
180	/Medic	al	4a. Facility Name (If not institution, giv	e street and number)	110			Location of Death	07	4c. Co	ounty of Death	LIGHT
-K	Examin	er	Anne Arundel M		2			polis			nne Aru	
	Funeral Director		5. Social Security Number 201–14–2767		yrs. last birth		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Sept. 9	ıy, Year)	9. Birthp Court	lace (State or Foreign try) A
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c	. City, Town	or Loca	tion				1	0d. Inside City Limits
	Mary a-f she	ctor	Maryland Anne A	rundel	Pa	sade	ena					1 ☐ Yes 2 🔼 No
	h with the 23a or 28: Ist be not	Funeral Director	10e. Street and Number 116 North Caroli	na Ave.			10f. Zip Code 2 <b>11</b> 2	2			en of What Cour JSA	try?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is its after traumatic by notified at once.	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1	în U.S.		as Decedent of H /es, specify Cuba □Yes 2√√No	ispanic Origin? (S in, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		Race - Americ Black, White, o Pecify: Whi	etc.
Baltimore, Maryland 21215-0036	vithin 72 ho ane. Ihan "natul	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)		Give ki life. DC	nt's Usual Occup nd of work done o DNOT use retired aker	ation during most of wor l)	king		of Business/Ind	dustry
d 2	filed w Hygie other t	ဝ	11th  17. Father's Name (First, Middle, Last	)	no	mema	aker	18. Mother's Nan	ne (First, Middle			
lan'	Aental rked o	To Be	George	Richter				Kathr	yn	I	Luebbert	
Mary	s 1 and 2 shou of Health and N item 27 Is ma other trauma		19a. Informant's Name/Relationship Mary K Sullivan	Type. Print) daughter	19b. I			and Number or Ru Drive.				Code)
more,	Pages 1 and the sent of He int: If item iry or other		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Hemovai Irom State			tion (Name of Itory or other plac en Cemet		Date 7/09		ation - City or To Burnie	· =
Balti	permit. Departn Importa any inju		21. Signatu of Funeral Service lice	ngee /		1	Name and Addres	ss of Facility S tain Roa	talling: d Pasade			ne P.A.
	Physician	11 3	23a. Part 1. Enter the disease, or con shock, or heart billure. List only Immediate Cause (Final	I vations that caused the e cause on each line.	death. Do no							Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a cor	nsequence of	): (	Λ.	7 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		0		3 1/
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	bDue to (or as a cor	nsequence of	):	(a)	unary	Will	7/2	slan	ylon
, 0,	rtificate be executed og physician and as the burial-transit	I Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a cor	nsequence of	·):						
68760,	icate t physic the b	<b>l</b> edical	•	d								
O. Box	eath cer aftendir for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death		Ectopic pregnanc Other <i>(specify)</i> _	у		23	3d. Date of deliv Month	ery Day Year
rds, P.	law requires that the de as been signed by the 2 should be detached	þ	Part II. Other significant conditions	contributing to death but no	t resulting in	the und	lerlying cause giv	en in Part I.		23e. Did tobacco use contribute to the cause of c		
Division of Vital Records,	t: The law red icate has bee i, page 2 shou	Completed							1 □ Yes	psy ormed? 2. No	prior to co death?	psy findings available impletion of cause of
Ζİ	slciar certif irector	Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	2 🗆 EB/Out	nationt	3□ DOA Oth	er:	ath (Check only lome 5 Res		Other (Case)	6.)
٥٥	g Phy ter this neral d	n: To	27. Manner of Death	28a. Date of Injury (Month, Day, Yea			28c. Injur Worl		28d. Describe			
Sior	endin eath. or: Af	catio	1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be	n		, u., y		Yes 2 □No				
Di <u>Xi</u>	tal or Att rs after de al Direct led in by t	Certification:	3 ☐ Suicide 6 ☐ Could not to determined		At home, farr pecify)	n, stree	et, factory, office		28f. Location ( City or To	Street and wn, State)	Number or Run	al Route Number,
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	(Check only 2 Medical Exa	hysician: To the best of my miner: On the basis of exa and manner stated.			estigation, in my o	ppinion, death occi		, date and p	place, and due t	o the cause(s)
	To vith	2	29b. Signature and title of certifier	* Aut	M		29c. Licens	2143	8	29d Date	signed (Month,	2009
_	10 V		30. Name and address of person who	CENIAM	1, 44	Type, P	DEFENS	EHGH	WAZA	VNA	PucisN	102140/
	Sta Registi		31. Datè filed (Month, Day, Year)  JUL 15	2009 Senema	Signature	4	ares		, 			

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			State C  State Registrar		eartment of Health and ertificate of Death	d Mental Hygien	71111	22483
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  WORTH B, DANIS	els, JR.	Tu ou Tu under de De	1114 9	Day Year 2009	3. Time of Death
- AL	Examin Funeral		4a. Facility Name (If not institution, give street and not institution) ROAD  5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	4b. City, Town, or Location of De BALTIMORC  If Under 1 Year   If Under 24 H Months   Days   Hours   M			nplace (State or Foreign
	Director		2   2 - 40 - 0   32   1 M M 2 □ F  Usual Residence of Decedent  10a. State   10b. County	Yrs.		NAN 3, 19	25 INEN	10d. Inside City Limits
	the Maryla 28a-f sho	rector	MARY LA NO 10e. Street and Number	BALTIM	10f. Zip Code	10g. C	Citizen of What Cou	1 ☑Yes 2 ☐ No untry?
	death with	Funeral Director	210 KIDGEWOOD KOAD 11. Marital Status 12: Was Dearmed F.	edent Ever in U.S. 13.	220 . Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - Amer Black, White	
5-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show Iteal Evrocit at course to conflict at	þ	1 □ Never Married 2 ☑ Married 1 □ Yes If Yes, G 3 □ Widowed 4 □ Divorced Year or [	2 Mo ive Dates:	1 □Yes 2 ☑No Specify:		Specify: Kind of Business/I	HITE _
21215-	within ene. than "	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (	1-4or 5+)	e kind of work done during most of v DO NOT use retired) HYS CAAA	working H	ACTH C	ARE
	ould be filed I Mental Hygi sarked other satic event, I	To Be (	17. Father's Name (First, Middle, Last)  NORTH B. DANIELS	SR.	JOSEP	Name (First, Middle, Maide HINE P. JA	NUARY	
Baltimore, Maryland	1 and 2 sh Health and tem 27 is m		19a. Informant's Name/Relationship (Type. Print)  ANE W PANES SI	DUSE   210	ling Address (Street and Number or FLOGEUOD ROAD position (Name of ematory or other place) FSL	BAUTIMORY	cocation - City or 1	AND 21210
altimo	permit. Pages Department of important: If it any injury or o		1 ☐ Burial 2  Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	SIANS FUN	ematory or other place) [SE] ERY UffE - AIR JUL 22. Name and Address of Facility [	4 11, 2009 FOR	EST HILL AD MONK	MARYLAND
a I	permi Depar impor any ir		23a. Part 1. Enter the disease, or complications that shock, of heart failure. List only one cause on	caused the death. Do not er	VANS FUNERAL CHAR nter the mode of dying, such as care	diac or respiratory arrest,	ON SERVICE	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease) or condition	ongestive (or as a consequence of):	Heast Fa	ilure	10	Onset and Death
	Examiner	Examiner	cause. Enter Underlying	(or as a eurocyclines of):	pathy			unknow
3760,	cate be executed by sician and the burlat-transit	lical Exar	Cause (Disease or injury that initiated events resulting in death) Last  Due to	(or as a consequence of):				
O. Box 68	ath certific attending p for use as	Physician/Med	in the past 12 months?	gnant at time of death 5	☐ Ectopic pregnancy		23d. Date of del Month	ivery Day Year
rds, P.	quires that en signed b uld be deta	ed by Pt	Part II. Other significant conditions contributing to a	teath but not resulting in the	underlying cause given in Part I.		1	the cause of death?
I Reco	: The law re cate has bed page 2 sho	Completed by	Lower gastroinfe Colonic ulce	stonal blee	e ding	24a. Was an autopsy performed' 1 □ Yes 2 ☑	prior to death?	atopsy findings available completion of cause of 2 □ No
of Vita	hysicfan: this certifical director,	Be		Inpatient 2 ER/Outpatie	ent 3 DOA Other: 4 Nursin	Death (Check only e)  ng Home 5 PResidence		cify)
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Certification: To	2 Accident investigation 3 Suicide 6 Could not be	e of Injury nth, Day, Year)  28b. Time Injury  e of Injury - At home, farm, s ding, etc. (Specify)	Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how in 28f. Location (Street City or Town, St.	and Number or Ru	ural Route Number,
	ne Hospita n 24 hours ne Funeral	Medical C	(Check only 2 Medical Examiner: On the	ne best of my knowledge, dea basis of examination and/or nner stated.	ath occurred at the time, date and p investigation, in my opinion, death o	lace, and due to the cause occurred at the time, date a	e(s) and manner as and place, and due	s stated. to the cause(s)
	To th	M	29b. Signature and title of certifier	lonner	29c. License number	2129	Date signed (Mont	h, Day, Year)
			30. Name and address of person who completed cat	Lonnell!	MD. 6301 N.	Cherles S	SH'B	Thimore
	Sta Registi		31. Date filed (Month, Day, Year)  JUL 1 5 2009	Registrar's Signature	artes			

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WORTH B. DANIELS, JR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep  1 - State Registrar Ce	artment of Health and N <i>rtificate of Death</i>		giene <sub>Reg. No.</sub> 2 () () 9	22484
i i	Physicia	an	1. Decedent's Name (First, Middle, Last)  Esther Ruth Delaney		2. Date of De July 8	ath Year Year	3. Time of Death 7:10 a. M
and a	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	th		
ne e	Funeral		Holy Cross Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Silver Spring  If Under 1 Year   If Under 24 Hrs.	8. Date of Bir	Montgome 9. Birt	thplace (State or Foreign
	Director		216-14-1019 1□ M XX F 85 Yrs.	Months Days Hours Min.	Dec. 9	, 1923 Mar	yland
	yland how		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	he Mar 28a-f s	ectol	Maryland Montgomery Gaithersb	1rg 10f. Zip Code		10g. Citizen of What Co	1 ☐ Yes 2 No
	h with t	al Dir	24200 Clematis Dr.	20882		United Stat	•
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinar mant be rutified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  14. Yes 2 No  If Yes, Give, W Year or Date! W II	Was Decedent of Hispanic Origin? (Sr If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	pecify Yes or No Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
21215-0036	72 hou "natura dical E	Completed	15. Decedent's Education 16a. Dec	edent's Usual Occupation  e kind of work done during most of work	king	16b. Kind of Business	/Industry
2121	d within giene. ir than ir e Mi	omo		DO NOT use retired)		Public Sch	ools
and	be filed ntal Hy ed othe event,	Be	17. Father's Name (First, Middle, Last)  Isaac Stakem	18. Mother's Nam Henriett		, Maiden Surname) o	
Maryland	should and Me s mark umatic	To	19a. Informant's Name/Relationship (Type. Print) 19b. Mai	ing Address (Street and Number or Ru	ral Route Numb	er, City or Town, State,	
e, Z	and 2 Health am 27 is			Clematis Dr. Gai		rg, Marylan	
altimore,	Pages rent of hit: If ite			osition (Name of matory or other place)  Ke Crematory 200	11, 9	-	, Maryland
Balti	permit. I Departm Importa any Inju		21. Sign ture on uneral Service Licensee	22. Name and Address of Facility Ra 1933 Gist Ave. Silv			
ı			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory a	arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Septic Shock  Due to (or as a consequence of):				
	Examiner	L	Pneumonia				
y.	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underthing Cause (Disease or injury that initiated events				
90,	ficate be executed physician and s the burial-transit		resulting in death) Last				
	ificate t g physic as the b	edica	d				
O. Box	Physician: The law requires that the death certific this certificate has been signed by the attending praid director, page 2 should be detached for use as	Physician/Medical		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of de Month	Blivery Day Year
ď.	s that the	by Phy	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did	tobacco use contribute t	to the cause of death?
ords	w requires that s been signed t should be deta						Probably 4K Unknown
al Rec	<b>hysician:</b> The law his certificate has b I director, page 2 sl	Completed			1 □ Yes	prior to prior to death? 2.5.7 No 1 □ Ye	utopsy findings available completion of cause of
Ξ	ysiciar is certil directo	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 No Hospital: ☐ Inpatient 2 □ ER/Outpati	26. Place of Dea ent 3 □ DOA Other: 4 □ Nursing H		one) idence 6 □Other (Sp.	ecify)
o u	ding Phy h. After thi funeral c	on: T	27. Manner of Death 1 X Natural 5 ☐ Pending  28a. Date of Injury (Month, Day, Year)  28b. Time Injury	of 28c. Injury at Work?	1	how injury occurred	
Division of Vital Records,	deatl ctor: / the	Certification: To	2	M	28f. Location ( City or To	(Street and Number or F wn, State)	Bural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.				
	To the within To the Comple	Med	29b. Signature attortife of certifier	29c. License number		29d. Date signed (Mon	nth, Day, Year)
	,		Majarsany, MD	D00672	279	Tuly 8th	5 209
	H+1		30. Name and address of person who completed dayse of death (Item 23a) (Type Suganthi Alagarsamy Veerappan, M.D.	9000 Franklin Sq.	Dr. Bal	Ltimore, MD	21237
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature				

DHMH 17 Rev 1/2001

09-05292 Delonte Elliott Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

elonte Elliott		Sta I-For State Registrar	ate of Mar	yland /		rtment of tificate of			Menta	al Hyg		eg. No.	200	9	2248
Physicia	n/	1. Decedent's Name (First, Middle									Date of Dea Month	Day	Year		e of Death 33 hrs
ledical Examir	ner	Delonte Elli					O: -				luly 5, 20	09	County of Deat		33 1115
		4a. Facility Name (if not institution Prince George's Hosp	_	d number)		4	Cheve		ocation of	Deam			nce Georg		
Funeral		Social Security Number	6. Sex	7. Age	e (In yrs. la	ast birthday)	If Unde		If Under	24Hrs. 8	B. Date of Bir	th(MM/DI	D/YYYY) 9. Bi	rthplace	(State or Foreign
Director		F70 17 1714							Hours	Min.	03/1//	1020	Country)  Washington, DC		
	ŀ	5/8–17–17/14   1 x M 2 F   20 Yrs.   03/14/1989   Wash									яшы	ui, ic			
any		10a. State 10b. County			10c. City,	Town or Location	n								nside City Limits
Aaryland 28a-f show 3 at once.	5	D.C.			Wa	shington									Yes 2 No
Maryla 28a-f d at o	Director	10e. Street and Number					10f. Zip				1	0g. Citize	n of What Co	untry?	
th the Maryland 23a or 28a-f sho notified at once		3981 Blaine Stree							019			1.	USA		
th wit	Funeral	11. Marital Status  1 Never Married 2 Ma		Decedent ed Forces?					anic Origir Mexican, F		ify Yes or No can, etc.)	)- 1	<ol><li>Race - Ame White, etc.</li></ol>	erican Ind	dian, Black,
er dea		41	1 Y	es 2	x No		Yes 2	X No	snecify:			s	specify: bl	ack	
urs aft urral"	5	15. Decedent's Education (Spe	or Dates:		npleted)	16a. Decedent				nd of wor	k done		nd of Business	/Industr	у
72 hou	eted	Elementary/Secondary (0-12)		ge (1-4 or		during mo	st of work	king life. [	OO NOT u	se retired	1)				
5-0036 led within 72 Hygiene. other than '	Comple	12th					Stude	nt				E	ducation	1	
5-0 iled w Hygie		17. Father's Name (First, Middle,	Last)		-			18			irst, Middle,		urname)		
21215-0036 Uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	o Be	Bobby Henry  19a. Informant's Name/Relations	hin (Tuna Drint	\		10h Mailing	Address	/Stroot			Elliot		y or Town, Sta	te Zin C	ode)
MD 21215-0036 d 2 should be filed within 77 th and Mental Hygiene. n 27 is marked other than tumatic event, the Medical	ř	Terri M. Elliott											DC 2001		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
ore, MD 21214 is 1 and 2 should be fill of Health and Mental I If item 27 is marked fer traumatic event, i		20a. Method of Disposition				Place of Disposi	tion (Nam				Date		ocation - City		State
nore, MD 2121 ages I and 2 should be fi nt of Health and Mental I it: If item 27 is marked other traumatic event,		1 X Burial 2 Cremation		val from St	are	crematory or oth		Darde		07/11	/2009	Ta	mbver,	Marsi	Free
[ 등 를 을 을 걸.		4 Donation 5 Other State 21. Signature of Funeral Service		-	110	22. N	ame and	Address	of Facility	<b>3</b>	n Funer	2) Co	mriana	ren y.	au
Balt permit. Depart Impor injury	18	1/1/1	h 11	em	ar	) 45	94 Pe	ech Ro	ı Tefer	reale Teale	Hills.	ar se Marv	land 20	748	
Physician		23a. Part I. Enter the disease, or failure List only one cause	complications t	hat caused	I the death	. Do not enter th	ne mode o	f dying, s	uch as cai	rdiac or re	espiratory ar	rest, shốc	k, or heart	Apr Be	proximate Interval tween Onset and
/Medical caminer		Immediate Cause (Final disease	N. Heimle	Gunsh	ot Wour	nds			_						Death
· ·		or condition resulting in death)	Due to (or	as a cons	equence o	of):									
	er	Sequentially list conditions, if any, leading to immediate	Due to (or	as a cons	equence o	of):	<u> </u>		,					+	
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	C.											-1	
ted Insit	Exa	events resulting in death) Last	Due to (or	as a cons	equence o	or):									
0, be executed sician and ourial - transit	edical	UNPENDED	AMENE	ED											
60, ate be hysici	Wed	IF FEMALE:	23c. If	yes, outco	me of preg	nancy						23d.	. Date of deliv	ery	
Box 6876( e death certificate the attending physed for use as the b	sician/M	23b. Was decedent pregnant in the past 12 months?	ne 1 1	ive birth		2 Fe	tal death	3	Ectopic	pregnand	СУ		Month	Day	Year
eath c atten for us	sici	1 Yes 2 No 9 Un	lenaum T	Pregnant a Unknown	t time of de	eath 5 Ot	her (Spec	cify)				0.000			
s, P.O. Boires that the de signed by the	Phy	Part II. Other significant condit			th but not i	resulting in the u	ınderlying	cause gi	ven in Par	t I.	23e. Did	tobacco u	se contribute	to the ca	use of death?
P.O. es that the igned by be detach	d by										1 Y	es 2 🗸	No 3 P	robably	4 Unknown
ords, w requir	Completed										24a. Was				findings available etion of cause of
e law te has	mp										perf	ormed?	death	?	2 No
Vital Rec ysician: The his certificate	ပိ	25. Was case referred to medica	al					26.Place	of Death (	Check on					
Vita hysicia this cer	Ö	examiner? 1 ✔ Yes 2 No	Hospital: 1	Inpati	ent 2 🗸	ER/Outpatient	3 0	OA	Other <sub>4</sub>	Nursing	Home 5	Resider	nce 6 Ot	her:	
ing Ph	n:T	27. Manner of Death	28a.	Date of Inj Month, Dey, UND:	ury Year)	28b. Time of I	njury		y at Work?	S	8d. Describe ubject sh		ry occurred		
ion ttendi leath. tor:	atio			UND: 5, 1909		FOUND: 1633 hrs		1 Y	es 2 🗸	No					
Division of Vital Records, pital or Attending Physician: The law require ours after death.  eral Director: After this certificate has been si filled in by the funeral director, page 2 should b.	Certification:		ld not be			nome, farm, stree	et, factory	, office bu	uilding, etc		or Town,	State)			oute Number, City
D spital hours neral y fille	Cer	4 V Homicide		ecify) Si									, Washingto		
Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the b	ica	(Check paly   Certifying P	hysician: To the miner:On the b	e best of n asis of exa	ny knowled amination a	dge, death occur and/or investiga	red at the tion, in my	time, da popinion,	te and plac death occ	ce, and d curred at f	ue to the car the time, dat	use(s) and e and pla	d manner as s ce, and due to	tated. the cau	se(s)
To T Com	Medical	29b. Signature and title of certifi	and mar	ner stated				c. License					Date signed (I		
		$\cap$	011	//	1			O.C.N	Л.E.			July	6, 2009		
		30. Name and address of person	who complete	d cause of	death (Iter	m 23a)									
		. /	puty Chief N	1edical E	Examine	er 111 Per		et, Balt	imore, N	MD 212	201				
St	ate	31. Date filed (Month, Day Year	no A	32. Registr	ar's Signa	ture/ Curke									
Regist	17:11		IUU /		-										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 906 A M **Physician** 2009 OCCO /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** University of Maryland Medical Center Baltimore 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days 1 MM 2□ F Hours Min. 212-74-4762 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantmer must be notified as once. 10d. Inside City Limits 10h County 10c. City. Town or Location 10a, State 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21236 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Çuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No 14. Bace - American Indian. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Completed by Specify: 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Şecondary (0-12) College (1-4or 5+) Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #102 20c. Location - City o Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses ISUANS FUNGRAL CHAF Approximate Interval Between Onset and Death 23a. Part 1. En of the diserce, or comshock, or self failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Preumonia **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □ Yes 2 □ No. 9 Unknown ate has been signed by to page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗀 No 1 □ Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Matural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 □Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

P.O. Box 68760 Division of Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

> State Registrar

Medical

29a. Certifier

25 Green Street

and manner stated.

person who completed cause of death (Item 23a) (Type, Print)

2

32. Registrar's

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

17525

Baltimore

29d. Date signed (Month, Day, Year)

2009

Ulu

Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician Month 805 AM Phyllis Jane Florian 12 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FRANKLIN Square Hospital Center Baltimore Rosedale 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 1□ M 2 F Hours 214-64-3722 55 **Director** Feb. 1, 1954 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Modical Examinar must be not lined at Director Baltimore Rosedale 1 ☐ Yes 2X No MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 14 Armor Court 21220 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☑ Married 21215-0036 1 ☐Yes 2 ☐ No Be Completed by If Yes, Give Year or Dates: Specify. white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) At Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) 2 should be fi Herbert Carl Robinson Ethel Jane Harrison ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any Injury or other trau Pages 1 and 2 14 Armor Court-Baltimore, Maryland 21220 Michael Florian-spouse more. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-17-09 Forest Hill, Maryland chapel and crem, services 22. Name and Address of Facility 21. Signatque of Funeral Service Licensee 8800 Harford Road Parkville,Maryland 21234 EVANS FUNERAL CHAPEL AND CREAMTION SERVICES 4 NE trade envise 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Fatal **Physician** Arrhy resulting in death) /Medical Due to (or as a consequence of): Examiner rTER Cononary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physlclan: The law requires that the death certificate be executed Hupertension
Due to (or as a consequence of): the attending physician and hed for use as the burial-tran Division of Vital Records, P.O. Box 68760. Physician/Medical Diabete IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☑ No 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □ No 24a. Was an has autopsy performe this certificate 1 □Yes 2 ☑No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ical 29a. Certifier

filled in by the funeral 24 hours after deatle Funeral Director: within 2 the

177hud

Occin

State Registrar

(Check only one)

DRMIChael

29b. Signature and title of tifier

DHMH 17 Rev 1/2001

000 FRANKLIN

30. Name and address of person who completed cause death (Item 23a) (Type, Print)

PIPKIN

and manner stated.

Sauare

OR Balto

29d. Date signed (Month, Day, Year)

3

ind

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2:074. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 7 Day **Physician** elen Franz 2009 /Medical 4c. County of Death
BALTIMORE 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PARKVILLE OAKCREST VILLAGE 0 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 1 □ M 2 🔽 F 90 218-09-1656 Director 7/12/0 JULY 12,1919 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinat must be notified at Director BALTIMORE PARKVILLE MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21234 8830 WALTHER BLVD UNIT 130 Funeral Frank, Helen Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: ۵ WHITE 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ANNA SOTER RICHARD BALTUS ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11114 TOWOOD RD KINGSVILLE, MD 21087 DAVID FRANZ-SON Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 7/18/09 GARDENS OF FAITH 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC 21. Signature of Funeral Service Licenses BALTIMORE, MD 21206 6415 BELAIR RD 23a. Party. Enjer the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Alzheimers /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a c Examine The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE yes, outcome of pregnancy

Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month 5 ☐ Other (specify) P.0. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy certificate 1 ☐ Yes 2 ☐ No 1 🗆 Yes 2 No Hospital or Attending Physician: funeral director. 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 🕱 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident after death filled in by the 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral

State

To the Hosp within 24 ho To the Fune completely f

Registrar DHMH 17 Rev 1/2001

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29a, Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day,

**ORIGINAL** 

Baltimore, Maryland

29d. Date signed (Month, Day, Year)

2:07 a. M

NY

Approximate Interval Between Onset and Death

Year

1 ☐ Yes 2X No

29c. License number

H 0052065

7/12/2009

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8800 Walther Blud.

and manner stated

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 7.45 AM 2009 th Lafayette S. Grier Sr. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) hus pital altimore Raltimore O If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 81 Months Days 1 X M 2 □ F Hours 5/31/1928 MD 219-22-1884 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1X Yes 2 □ No Baltimore MD na 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21215 USA 5406 Wabash Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status rmed Forces? XYes 2 ☐ No Black, White, etc. 1 Never Married 2 Married Black If Yes, Give Year or Dates: 1 ☐Yes 2 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 2yrs Health Care 12th <u>Analyst Assistant</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jennie Lee James Grier 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 5406 Wabash Avenue Baltimore, MD Juanita Grier/wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Garrison 7/14/09 Owings Mills, MD Forest 21. Signature of Funeral Service Licensee 4300 Wabash Avenue Baltimore, MD March FH West Approximate Interval Between Onset and 23a. Part 1 Enter the disease, or complications that cause 1 the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Between set and Death Immer ate Cause (Final disease or condition resulting in death) week Due to (or as a consequent of): neumon Sequentially list conditions, if any, leading to himmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last idney Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 | No 3 | Probably 4 | Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 ☐Yes 2 ☐No 2 No 1 ☐ Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify)

**Physician** /Medical Examiner

certificate be

P.O.

of Vital Records,

Division

Physician

/Medical

Examiner

**Funeral** 

Director

show

Director

Completed by Funeral

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27 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Madical Eventions and the Indianal

other

permit. Pages Department of Importent: If it any injury or o once.

the Maryland

Baltimore, Maryland 21215-0036

. 1 and 2 should be the Health and M

attending physician end for use as the burial-transit signed by the a been si should b To the Hospital or Attending Physiclan: The law within 24 hours after death.
To the Funerel Director: After this certificete has completely filled in by the funeral director, page 2:

Exami Physician/Medical <u>چ</u> Completed Be Certification: To

25. Was case referred to medical examiner? 1∐ Yes 2 ☑ No

29b. Signature and title of certifier

27. Manner of Death Natural 2 ☐ Accident 3 🗌 Suicide 4 Homicide

31. Date filed (Month)

29a. Certifier

Medical

5 ☐ Pending investigation 6 ☐Could not be determined

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 hpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 91). M001

Registrar's Signatu

29d. Date signed (Month, Day, Year) 09

State

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Joseph Francis Gumnick July 12 2009 1:11 DM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 104 Springview Court Timonium Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days 1 № 2 □ F 212-20-7785 83 Yrs. 10/25/1925 Balt. Raryland Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Timonium 1 □ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 104 Springview Court 21093 Funeral America 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ∑Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: white Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore Gas Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer & Electric Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael B. Gumnick Mary Rose Schap 2 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Edith R. Gumnick/ wife 104 Springview Court Timonium, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley 20a. Method of Disposition Date 20c. Location - City or Town, State purial 2 ☐ Cremation 3 ☐ Removal from State July 16, 4 Donation 5 Other (Specify) Memorial Gardens 2009 Timonium, Maryland 21. Signature of Funeral Service Licensee Peaceful Alternatives Funeral & Cremation Ctr., P.A 2325 York Road Timonium, Maryland 21093 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PULMONANT HYPERTENSION disease or condition resulting in death) YEARS Due to (or as a consequence of): PULMONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of). SCITES resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Hamicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal (Check only one)

spital or Attending Physician: The law requires that the death certificate be executed ours after death.

First Director: After this certificate has been signed by the attending physician and filled in by the turnelal director, page 2 should be detached for use as the burlar-transit Division of Vital Records, P.O. Box 68760, Hospital of hours a within 24 hours

**Funeral** 

Director

r items 23a or 28a-f show increwst be notified at

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Important: If it any Injury or c once.

Pages 1 and 2 should be finent of Health and Mental I

of Health a

Department

**Physician** 

Examiner

/Medical

Maryland 21215-0036

Saltimore,

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, 32. Registrar's Signature Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MMASMO

29b. Signature and title of certifier

ATTENPINE PHYSICIAN

8320 Bellows Ave

00025

29d. Date signed (Month, Day, Year)

SUITE 120 TOUSONMOZIZOT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Day Month **Physician** Hawkins 07:19 PM averne 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE AGNES HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Months Days Hours 220-64-3096 1 ☐ M 2 💢 F Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Eventhar must be notified at 1 Yes 2 □ No Director MD ti more 10g. Citizen of What Country? 10e. Street and Number USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 3 Widowed 4 Divorced Baltimore, Maryland 21215-0036 Blac 1 ☐Yes 2 No <u>۾</u> Completed 16a. Decedent's Usual Occupation (Giverkind of work done during most of working life. IPO NOT use retired) 16b. Kind of Sociness/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any Injury or other traumatic event, Item Mental Injury or other traumatic event, Item Men College (1-4or 5+) Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number of **Brother** Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part1. Enter indicisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SARCOM4 TO LUNGS AND YEARS **Physician** METASTATIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and burial-trar Due to (or as a consequence of): Box 68760. ician Physician/Medical attending phy nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months?
1 Yes 2 XNo Month Year Day 4 Pregnant at time of death 5 Other (specify) detached signed by the 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, DIABETES MELLITUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ¥ Unknown Completed CONGESTIVE 24b. Were autopsy findings available prior to completion of cause of death? HEART FAILURE 24a. Was an certificate has autopsy perforn HYPERTENSION 1 Tes Division of Vital 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To completely filled in by the funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 24 hours after deat e Funeral Director: 6 □Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 121798 MD JULY 2009

900 CATON AVENUE

NARYLAND

BALTIMUKE,

ORIGINAL

Registrar
DHMH 17 Rev 1/2001

State

4AWKINS

15

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BHAVANDEEP

31. Date filed (Month, Day, Year)

	1 - State Registrar	State of Maryland / Dep Ce	rtificate of Death		Reg. No.	09 2249
/sician ledical	1. Decedent's Name (First, Middle, Last) Barbara Jean Ja	ackson		2. Date of De Month July	Day \	3. Time of Death 12:03 P.M
aminer	4a. Facility Name (If not institution, give stre Stella Maris Hosp		4b. City, Town, or Location of Timonium	Death	4c. County of Balti	
eral ctor	5. Social Security Number  577–52–2173  Usual Residence of Decedent	7. Age (In yrs. last birthday) 71. Yrs.	If Under 1 Year If Under 2 Months Days Hours	4 Hrs. 8. Date of Bi (Month, D 2/21/	irth (2ay, Year) (1938   W	9. Birthplace (State or Foreign Country) (ashington, D.
fled at tor	10a. State 10b. County Maryland Baltimore	10c. City, Town or Lo				10d. Inside City Limits
any injury or other traumatic event, the Medical Eventual and confidence once.  To Be Completed by Funeral Director	10e. Street and Number 3 Glenwood Road		10f. Zip Code 21221		10g. Citizen of Wh United of Amer	States
by Funeral	1 Never Married 2 Married	1 □Yes 2√∑No	Was Decedent of Hispanic Origi If Yes, specify Cuban, Mexican, 1 □Yes 🏖 No Specify:	in? (Specify Yes or No Puerto Rican, etc.)	o- 14. Race -	American Indian, White, etc. Black
Completed	15. Decedent's Educati (Specify only highest grade co	Ompleted) (Give College (1-4or 5+)	dent's Usual Occupation kind of work done during most of DO NOT use retired) 1d Care	of working	16b. Kind of Busin	•
To Be C	17. Father's Name (First, Middle, Last)  John Maddox			s Name <i>(First, Middle</i> line Lower	, ,	
	19a. Informant's Name/Relationship (Type. Wr. Walter L. Jackson	,	ng Address (Street and Number enwood Road Ba	or Rural Route Numb altimore,		
	20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Rem  4 □ Donation 5 □ Other (Specify)		C(C) I (1 C (-211)	July 15,	20c. Location - Ci	ty or Town, State
once	21. Signature of Funeral Service Licensee	/ Pe	2. Name and Address of Facility aceful Alterna 2325 York Ro	tives Fune	ral &Crem	ation Ctr.,P.
n	23a. Part 1. Enter the disease, or complicity shock, or heart fallure. List only one of Immediate Cause (Final disease or condition resulting in death)	ns that caused the death. Do not entause on each line.  END STAGE RENAL D	er the mode of dying, such as ca	ardiac or respiratory a	arrest,	Approximate Interval Between Onset and Death
edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Line Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	Due to (or as a consequence of):  Due to (or as a consequence of):				
Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of Month	
<u>چ</u>	Part II. Other significant conditions contrib	uting to death but not resulting in the u	nderlying cause given in Part I.		37	ute to the cause of death?
Completed	11			24a. Was auto perfo	an 24b. We priormed? dea	re autopsy findings available or to completion of cause of other.
) Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	ital: 1 ☐ Inpatient 2 ☐ ER/Outpatier	044	f Death (Check only o		
ation: To		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	IL 3 DOA 4 Nurs	28d. Describe	how injury occurred	(Specify) HOSPICE
Certification: To	3 Suicide 6 Could not be 4 Homicide determined	8e. Place of Injury - At home, farm, strabuilding, etc. (Specify)	eet, factory, office	28f. Location ( City or To	Street and Number wn, State)	or Rural Route Number,
edical (	29a. Certifier  (Check only one) X Nurse Practit	an: To the best of my knowledge, death On the basis of examination and/or in Anoneer stated.	n occurred at the time, date and vestigation, in my opinion, death	place, and due to the occurred at the time,	e cause(s) and mann , date and place, and	ner as stated. If due to the cause(s)
M	29b. Signature and little of certifier	NP	29c. License number	2	29d. Date signed (/	Month, Day, Year)
	30. Name and address of person who compl		,		1101	
State	31. Date filed (Month, Day, Year)	2300 DULANEY VA	LLEY RD. TIMON	IUM, MD 2	1093	

DHMH 17 Rev 1/2001

JULY 11, 2009 12:03 p.m.

BARBARA JACKSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Day **Physician** 20 AM Ma 2009 141 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Maryland ince heorges Hospital lintor If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🕱 F 224-72-7335 September 21,1921 Virginia Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be martitled. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Walder 1 ☐ Yes 2 X No Funeral Director naries Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe aroline Circle 2060 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify 2 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) tac eamstre 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be tmma ranno ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Ty Caroline Circle Waldorf, Md 20601 JOSE Phine
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ▲ Burial 2 Cremation 3 Removal from State Bedford Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bed ford Funeral Home 21, Signature of Funeral Service Licensee obert 1039 Rock Castle Road Bedford, Virginia 24523 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final andiover by ration **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ata if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed the burial-trans Severe and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Year Month signed by the a d be detached for 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 3 Probably 4 Unknown 2 No 1 ☐ Yes should To the Hospital or Attending Proystorian. The last hours after death.

To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should be a second to the funeral director. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No pertensive 1 ☐Yes 2 ☐ No 1 ☐Yes of Vital 25. Was case reference examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Be o medical Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death
1 Natural
2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) D00 28035 9135 PITTAN CLINT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

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MD 20731

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To To

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

ORIGINAL

O.C.M.E

111 Penn Street, Baltimore, MD 21201

July 14, 2009

Registra

Laron Locke MD.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #30 per DVR 9893 //14/09 TT State of Maryland / Department of Health and Mental Hygiene [] [] 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dorothy Renee Jackson 2009 June 25, 1527P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Community Center PG Cheverly 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Months Days Hours Min. 1 □ M 2 □ F 358-34-7400 09/11/1942 66 Mississippi Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√Yes 2□No Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3525 A Street, S.E. #103 20019 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2☐ Married 1 ☐ Yes 2 ☐ No Specify Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) RN Nurse 2 years Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Brown Fannie B. Armstrong 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LeRoy R. Jackson - Husband 3525 A Street, S.E. #103; Washington, D.C. 20019 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State Resurrection Cemetery 07/02/2009 4 Donation \_5 ☐ Other (Specify) Clinton, Maryland 22. Name and Address of Facility Freeman Funeral Services 21. Signature of uneral Service Licenses ) 4594 Beech Road; Temple Hills, Maryland 20748 23a. Part 1. Enter the disease, or complication that used the death. Do not enter the mode of dying, such as cardiac or respirato shock, or heart failure. List only one cau e on, ach line. Approximate Interval Between Onset and Death immediate Cau e (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying course (Leader Underlying that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part if. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 ☐ Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury

**Physician** /Medical Examiner or Attending Physician: The law requires that the death certificate be executed sician and burial-trans attending physician for use as the buria

Box 68760.

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Records,

of Vital

Division

the Hospital

**Physician** 

/Medical

**Examiner** 

10a. State

D.C.

**Funeral** 

Director

28a-f show

Director

Funeral

2

Completed

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s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene.
Item 27 is marked other than "natural", or Items 23a or 28a-f show other thaumatic event, Item Medical Exhibitor than the notified at

permit. Pages 1 Department of H Important: If Ite any injury or ot

Baltimore, Maryland 21215-0036

Examine Physician/Medical been signed by the should be detached Completed by page 2 this certificate director, Be Certification: To within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral

25. Was case referred to medical examiner?

1 Yes 2 No

29b. Signature and title of certifier

27. Manyer of Death 1 X Natural 2 Accident 3 Suicide

4 Homicide

29a. Certifier

5 Pending Investigation

6 □ Could not be determined

28a. Date of Injury (Month, Day, Year)

and manner stated

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 3001 Hospital Dr. Cheverly, MD 20785 Demetrios Catevenis,

State Registrar

Medical

31. Date filed (Month, Day, Year) 15 2009 Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Ye ar Physician enes >35 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore HOOKINS Jahns view Mechical Lenter N/A5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 59 Yrs. 8. Date of Birth (Month, Day, Year) JULY 27, 1949 Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F Director 212-80-7760 GREECE Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r than "natural", or items 23a or 28a-f shoot the Medical Examination to notified at Director 1 ∏Yes 2 ☐ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 518 S. OLDHAM ST 21224 USA by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 □ No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 X No Specify. WHITE Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, tr. Insones, pones, ones. Elementary/Secondary (0-12) College (1-4or 5+) RESTAURANT SELF EMPLOYED 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental KONSTANTINOS KELEPESIS ARHONTOULA MINATSI 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JENNY KELEPESIS-WIFE 518 S. OLDHAM ST BALTIMORE, MD 21224 Baltimore. 20a. Method of Disposition 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) OAKLAWN CEMETERY 7/14/09 BALTIMORE, MD 22. Name and Address of Facility CHARLES S. ZEILER AND SON, INC. 21. Signature of Funeral Service Ligensee 6224 EASTERN AVE BATLIMORE, MD 21224 Approximate Interval Between Onset and Death 2.5 V 23a. Part 1. Enter the disease shock, or heart failure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to him sonate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to Carde a consequence off The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Smoking IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, à 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy perform certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 No Hospital or Attending Physician: 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ♣ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Sta

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
5740 Cross County Blvd. Balthmore

JUL 15 2009

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12:47 am Heung S. Kwon July 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 8402 Kimberland Circle Ellicott City Howard 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 T F Months Days Hours Min. Director 75 4/1/1934 Korea N/A Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show adiest Exactives munt by notified at 10a, State 10b. County Director 1 ☐ Yes 2 XNo Ellicott City Md. Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 8402 Kimberland Circle 21043 Korea Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?

1 Yes 2 No
if Yes, Give
Year or Dates: permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Modical Examina. once. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Asian Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 8yrs Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Byung Park Ki Kwon P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Esther Yeon Kwon/daughter-in-law 8402 Kimberland Circle Ellicott City, Md. 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ardent Crematory Inc. 7/16/2009 4 ☐ Donation 5 ☐ Other (Specify) Hanover, Md. 21. Signature of Funeral Service Lices 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 4112 Old Columbia Pike Ellicott City, Md. 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Cervical and Uterine Cancer with metastasis **Physician** years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Que to for sels nonesquence off Physician: The law requires that the death certificate be executed burial-tran and resulting in death) Last Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 23d Date of delivery 3 Ectopic pregnancy for Month Day Year 5 Other (specify) signed by the a o 9 Unknown 9 Unknown 9 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, \$ Hypertension 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Degenerative joint disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2: autopsy certificate 1 ☐ Yes 1 ☐ Yes 2 No 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1 🔀 Natural 5 ☐ Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D52544 July 15,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 700 Geipe Rd. #204, Catonsville, Md. 21228 Benjamin S. Lee, M.D., 31. Date filed (Month, Day, Year) State 1. park Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 7-1,30AM phen 2009 1 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** VA Community Living Certer Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 217-50-3024 1 **⊠** M 2 □ F 104/1949 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If tier 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 Tyes 2 No Directo Baltimore MD n/a 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21239 1215 Silverthorne Rd. USA Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 NYes 2 No Army If Yes, Give Year or Dates: 10/23/67-10/22/773 Specify: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: black þ 3 ☐ Widowed 4 😾 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Custodial Engineer Maintenance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Crews Onzelow Kendall ٥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1215 Silverthorne Rd. Balto, Md. 21239 Dorothy Kendall (mother) 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 2009 21 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Conation 5 ☐ Other (Specify) Veteran Cem. OwingsMills, Garrison Forest 22. Name and Address of Facility Calvin B. Scruggs Funeral Home Signature of Funeral Service Licensee E. Preston St. Balto, Md. 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final end stage cimhosis 04 the **Physician** Liver 4 years disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner leavs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 M Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Mark O. Hensel, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark D. Heuser 10. North Greene St. Balto. Md. 21201 31. Date filed (Month, Day, Year) - -State Registrar

			1 - State of Registrar	Maryland / Depa	artment of H			giene Reg. No.2 0 0 9	22499		
П	Di		Decedent's Name (First, Middle, Last)			***	2. Date of Dea		3. Time of Death		
	Physicia /Medic		Etta tuy Leng				JWY	10 20	09 0130 M		
Marie Tay	Examin	er	4a. Facility Name (If no institution, give treet and num  Mercy William (en Her		Baltino	r Location of Deat		4c. County of Death Bulling & City			
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 KF	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		h y, Year) 9. E <b>8 143</b>	Birthplace (State or Foreign Country)		
Ī	and ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation		•		10d. Inside City Limits		
	death with the Maryland ms 23a or 28a-f show	tor	TN	Nashv	ville				1 XYes 2 ☐ No		
	or 28s	Sirec	10e. Street and Number		10f. Zip Code			10g. Citizen of What	Country?		
	ath wi	ral	2416 Woodale Ave			204		U.S			
320	be filed within 72 hours after death with the Marylan ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Midfall Even.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 2 Divorced  12. Was Decer	2 XNo e	Was Decedent of H If Yes, specify Cuba 1 □Yes 2X No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		merican Indian, hite, etc. Black		
2-003p	2 hou	Completed	15. Decedent's Education	16a. Dece	dent's Usual Occup		rking	16b. Kind of Busine	ss/Industry		
7	ithin 7 ne. 'nan "r	mple	(Specify only highest grade completed)    Ielementary/Secondary (0-12)   College (1-12)   NA	life.	DO NOT use retired COMMUN	d)	-	Nortel	Services		
7	filed w I Hygier other th ent, th		17. Father's Name (First, Middle, Last)	Cer	.ecommun			Maiden Surname)			
yland	should be filed within and Mental Hygiene. marked other than matic event, In M	To Be	Eddie Lee White			Faye Ra					
Mar	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 Is marked any lijury or other traumatic e once.		19a. Informant's Name/Relationship (Type. Print) Sandra F. Long-Daugh					er, City or Town, State Apt 3,	Baltimore		
ore,	es 1 a of He fitem		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from S	20b. Place of Dispo	osition (Name of matory or other place	ce)	Date	20c. Location - City	MD 21201 or Town, State		
paltimol	t. Pag tment tant; l		4 □ Donation 5 □ Other (Specify)	Ennis	Memoria		8/09	Ennis, T	exas		
a D	permi Depar Impor any Ir		21. Signature of Funeral Service Licensee	$i\omega$	2. Name and Addre	ss of Facility I West	. Balti	more, Md	21215		
			23a. Pa. 1. Enter the disease, or complications that ca	aus d the death. Do not ent					Approximate Interval Between		
-	Physician /Medical		Immediate Cause (Final disease or condition possible)  Immediate Cause (Final disease or condition possiting in death)	unad Myccord	ial Infa	ction			Onset and Death		
	Examiner		(0)	or as a consequence of): MMM Adem [	Disease						
	₽ #	ner	cause. Enter Underlying	or as a consequence of)							
	ecute and trans	Examiner	Cause (Disease or injury that initiated events c	or as a consequence of):							
00,	e be ex sician s buria	dical E	$\mathcal{O}_{\mathcal{O}}$	um and a consequence on.							
00	rtificati ng phy as the		22	70.174.00							
O. DOX	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  Of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burlat-transit	Physician/Me	in the past % nonths?	ant at time of death 5	☐ Ectopic pregnanc ☐ Other (specify)	У		23d. Date of Month	delivery Day Year		
ř.	s that t ned by s detac		Part II. Other significant conditions contributing to de	ath but not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use contribute	e to the cause of death?		
ecords,	equires en sig ould be	ed b	Stage II Chronic Kidne	y Viseose,	Asthma	<u> </u>	1 🗆 \	res 2X1No 3□	Probably 4 Unknown		
Jaec I	The law re ate has be page 2 sho	Completed by	Hypertusion	0			24a. Was autop perfo i Dyes	an 24b. Were prior death 2 \( \text{No} \) 1 \( \text{N} \)			
<u>a</u>	Iclan; certific ector,	Be	25. Was case referred to medical examiner?  Hospital:		Oth		ath (Check only o	ne)			
5	Phys rr this eral dir	. To	27. Magner of Death 28a. Date of	patient 2 ER/Outpatier of Injury 28b. Time o	f 28c. Injur	ry at		dence 6 Other (S	Specify)		
VISION	nding ath. r: Afte e fune	atior	Natural 5 ☐ Pending (Month	h, Day, Year) Injury	Worl	ki? Yes 2 □No					
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Certification:	3 Suicide 6 Could not be determined 28e. Place buildir	of Injury - At home, farm, str ng, etc. (Specify)	reet, factory, office		28f. Location (5 City or Tov		Rural Route Number,		
	Hospita 24 hours Funera etely fille	Medical C	29a. Certifier 1 Certifying Physician: To the (Check only one) Medical Examiner: On the base and mann	asis of examination and/or in							
	To the within To the complete	Me	29b. Signature and title of certifier		29c. Licens	e number		29d. Date signed (M	onth, Day, Year)		
			1 Ques	20) mb	P2	2955		July 10	2009		
(	18		30. Name and address of person who completed cause Justin B. Long MD	301 St. Paul	Place E	Baltun	e. Mi	21202			
	Sta Registr		31. Date filed (Month, Day, Year)  JUL 15 2009  32. Re	egistrar's Agnature		- vive-Vi	-1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

09-05444 Timothy Long

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2009 Certificate of Death 1- For State Registrar 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day July 12, 2009 0111 hrs Timothy Long Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Westminster 1409 Deer Park Road If Under 1 Year | If Under 24Hrs. | 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Davs Hours MD 212-19-5827 Mar 31, 1976 Director 33 1 XM 2 F Usual Residence of Decedent 10d. Inside City Limits Oc. City, Town or Location À 10a. State 10b. County 1 Yes 2 No items 23a or 28a-f show ist be notified at once. Sykesville Carroll 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21784 5519 Mineral Hill Road 14 Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S Funera White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? other than "natural", or iten the Medical Examiner must l 1 X Never Married 2 Married 2 X No Yes White imore, MD 21215-0036
Pages I and 2 should be filed within 72 hours after of near of Health and Mental Hygiene.
ant: If iten 27 is marked other than "natural", o Yes 2X No specify: Specify: If Yes, Give Year Divorced Widowed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Home Improvement Sub Contractor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Patricia Anne Koby Carroll Thomas Long Be tranmatic event, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (parents)
Mr. & Mrs. Carroll Thomas Long 5519 Mineral Hill Road Sykesvill,e MD 21784 nt of Health a it: If item 27 other tranm 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Burial 2 X Cremation 3 Removal from State Sykesville, MD 7/17/09 All County Cremation permit. Page Department o Important: injury or oth Other Specify: 21. Signature of Funeral Service License HAIGHT FUNERALLY HOME & CHAPEL, PA PO Box 195 Sykesville, MD 21784 100764 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. Death Medical a. Head and Chest Injuries Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - transit Hospital or Attending Physician: The law requires that the death certificate be executed sician/Medical **AMENDED** UNPENDED 23d. Date of delivery Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy Year 3 Ectopic pregnancy 3h Was decedent pregnant in the Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown the Phy 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 1 Yes 2 ✓ No 3 Probably 4 Unknown ۵. Completed 24b. Were autopsy findings available Records, 24a. Was an s peen s prior to completion of cause of autopsy death? performed? has r this certificate had director, page 7 No 1 🗸 Yes 2 No ✓ Yes 2 26.Place of Death (Check only one) 25. Was case referred to medical Vital Be Other<sub>4</sub> examiner? Hospital: 1 Residence 6 V Other: Scene Nursing Home 5 Inpatient ER/Outpatient 3 1 Yes 28a. Date of Injury Jul 12, 2009 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death ŏ After Driver auto/fixed object (tree) collision Certification 0058 hrs 1 Yes 2 ✔ No Division Natural Pending in by the Director: 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be or Town, State) 1409 Deer Park Road , Westminster, Md. 3 Suicide determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie July 12, 2009 O.C.M.E. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Laron Locke MD.

ORIGINAL

32. Registrar's Signature

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State

Registra